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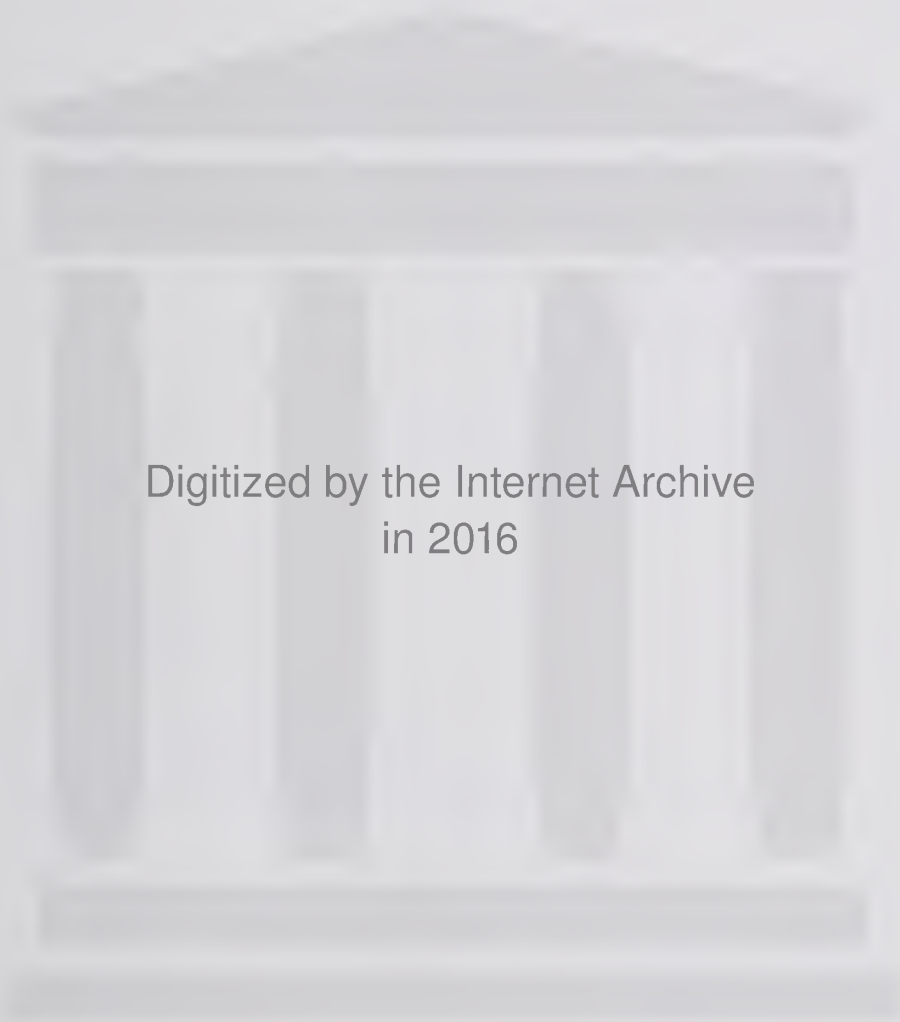
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OF THE KENTUCKY STATE MEDICAL ASSOCIATION

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Bladder Dysfunction

Repeated Gynecologic Surgery

See table of contents on page 4

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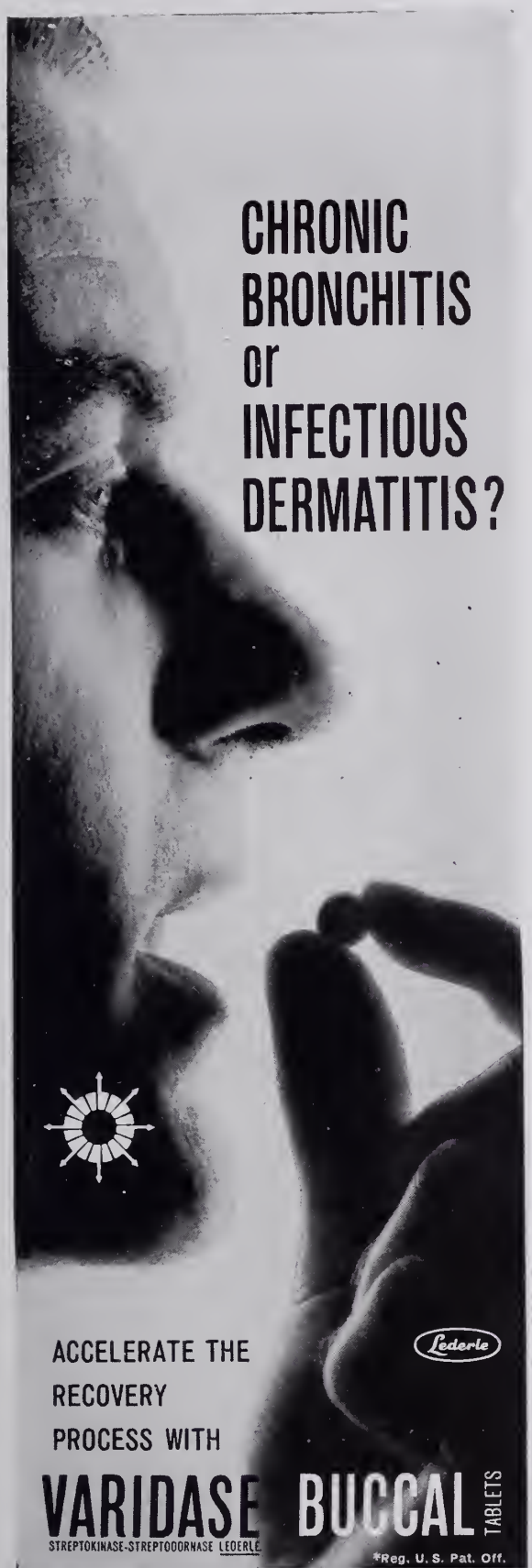
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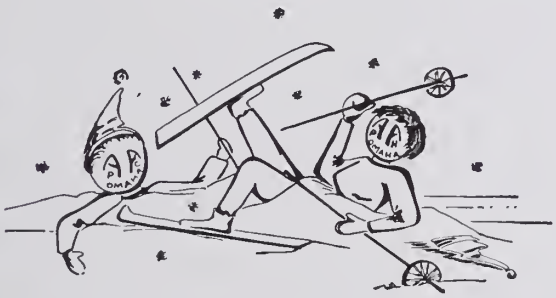
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message from the President

THIS is the first month of another year, and as we take inventory of our lives, we find many things we would like to forget. For one thing, we need to *forget our successes,* lest we become too self-satisfied and rest back on our laurels. So, we need to be very humble about our successes in the year just past.

On the other hand, we also desperately need to *forget our faults and failures.* I do not believe any of us can honestly say that he does not have something to forget . . . something he would like to put out of his mind and charge up to bitter experience. If, however, we are perfectly satisfied with the past twelve months . . . if there is nothing in your past that is not now a cause to regret . . . if any one of us has an absolutely clear conscience about every word spoken and every deed done; then plainly this message is not for him. Yet, as someone has said, "most people with a clear conscience, simply have a poor memory."

But, friends, even if we have led absolutely perfect moral lives in the last twelve months; have there not been *personal sorrows and griefs* that we long to leave behind us as we go forward into the year ahead? We must not nurse our griefs, nor hold our hurts. That way bitterness and mental illness lie. How can we learn the *fine art of forgetting* the bitter and remembering the best.

Listen to the Apostle Paul—". . . this one thing I do, *forgetting* those things which are behind, and reaching forth unto those before . . ." May 1959 be a very happy and prosperous year for all of you.

Robert W. Robertson

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reference s:

1 Grieble, H.G., and Jackson, G.G.: Prolonged Treatment of Urinary-Tract Infections with Sulfamethoxypyridazine. *New England J. Med.* 258:1-7, 1958

2. Editorial *New England J. Med.* 258:48-49, 1958.

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Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastenr Parkway, Louisville 17, Ky.

ESSENTIALS OF THERAPEUTIC NUTRITION: by Solomon Garb, M.D., published by the Springer Publishing Company, Inc.

HANDBOOK OF CARDIOLOGY FOR NURSES: Third Edition; by Walter Modell, M.D., and Doris R. Schwartz, R. N., published by Springer Publishing Company, New York.

PREVENTIVE MEDICINE IN WORLD WAR II: Volume IV, Communicable Diseases Transmitted Chiefly Through Respiratory and Alimentary Tracts; published by Major General S. B. Hays, The Surgeon General, U. S. Army.

THE BIRTH OF NORMAL BABIES: by Lyon P. Strean, Ph.D., published by Twayne Publishers, Inc., New York.

TREATMENT IN INTERNAL MEDICINE: by Harold T. Hyman, M.D., published by the J. P. Lippincott Company, Philadelphia and Montreal.

EMERGENCY TREATMENT AND MANAGEMENT: by Thomas Flint, Jr., M.D.; published by W. B. Saunders Company, Philadelphia and London, Second Edition, August, 1958; 539 pages; price, $8.

Dr. Flint's second edition of "Emergency Treatment and Management" is a most timely and worthwhile book of emergency treatment. For quick reference the book is divided into three main sections:

1. General Medical Principles and Procedures;
2. Emergency Treatment of Specific Conditions;
3. Administrative, Clerical and Mediolegal Principles and Procedures.

The subject in each division is alphabetically listed. In addition, the entire subject matter and contents of the book are divided into 129 topics. This subdivision of the book into topics is a unique time saver in obtaining information.

The fact that the book's outline of treatment is premised to a very great extent upon the equipment and the drugs that are ordinarily present in every doctor's office is in itself most desirable.

The information contained relating to the emergency treatment in each specific case is brief, but adequate, and basically sound. This is as it should be.

The topic on poisons is exceptionally complete. The subject matter is well arranged containing quick reference for emergency treatment. Poison is a subject so important in an emergency, yet frequently neglected in a book of this type.

The appendix and index are well arranged and exceptionally clear. One may obtain adequate information quickly and clearly.

"Emergency Treatment and Management" is a subject most of us are not too familiar with. Dr. Flint has prepared an atlas of reference, diagnosis, and the treatment of emergencies in a most common sense manner.

It is obvious that this book is the result of a vast amount of experience and knowledge of emergency care by the author.

For quick reference, in my opinion, this book should be in every doctor's possession during these trying times. Emergency care could become extremely important, in fact, it might well be our only available medical care.

Hobart D. Belknap, M.D.

PEDIATRIC INDEX: by Edwin F. Patton, M.D.; published by the C. V. Mosby Company, St. Louis, 1958; 639 pages; price, $13.50.

This book meets a restricted need for those who desire a quick differential of various symptom complexes. Section I is conveniently divided into three age groups: one, birth to two weeks; two, two weeks to two years; three, almost any age.

The second section deals primarily with diagnosis and gives one a quick summary of the more important findings in these various conditions. In addition, a short paragraph of treatment is included.

In the third section of the book are some practical suggestions and lists. For example, there is a list of all poison control centers in the United States and Hawaii.

In general, I believe this would be a handy book for quick reference, but would not advise its use as a substitute for the more complete text.

Joseph A. Little, M.D.

A METHOD OF ANATOMY: by J. C. Boileau Grant; published by The Williams and Wilkins Co., Baltimore, Sixth Edition, 1958, 879 pages, price, $11.

For years various publishing companies have been offering to the medical public two thousand page volumes mistitled "A Textbook of Anatomy." Actually these are encyclopedias of anatomy. Besides a detailed description of the gross anatomy of the human body they contain extensive, but incomplete, discussions of microscopic anatomy, of embryology, of neuroanatomy and sometimes of growth and development. They are designed primarily as refer-

ence books for the office of the practicing physician.

These same huge compendiums have been offered as textbooks to the beginning student in gross anatomy. Written from the systemic standpoint these so-called textbooks add detail upon detail of form, pattern and relationship, which often completely overwhelm the student's ability to separate the pertinent from the relatively unimportant.

One of several attempts to overcome this situation was "A Method of Anatomy" written by J. C. Boileau Grant, Professor of Anatomy at the University of Toronto. Published first in 1937 the 650 page text, illustrated with 564 live diagrams, almost stole the textbook of anatomy field.

Writing from the regional point of view the author attempts to describe the structures of an area in relation to the dominant anatomical feature of the region, be it a viscus, a muscle, a bloodvessel or a bony landmark. This method, the author insists, "leads inevitably to the apprehending of the underlying principles involved and the 'raison d'être' of such relationships." Emphasis is placed not upon the mere presence of a structure but upon the function it serves. Hence, the deductive new method. Illustrations and explanations from comparative anatomy and embryology are frequent and apt.

Written in a very dramatic style the author uses many ingenious diagrams and catch phrases to illustrate and emphasize his points and to make them stick in the minds of his readers. At times his "new method" of relating structures stretches the "raison d'être" to rather thin proportions. But, for the most part, his reasons for existing relationships are quite clear and acceptable. The text is dotted with poignant generalizations.

Twenty-one years and five revisions later, the 6th edition of "A Method of Anatomy" is a handsome volume, well printed and excellently illustrated by over 800 black and white diagrams and line drawings. Its text, repeatedly revised and rewritten, is now expanded to 879 pages. A modest bibliography is included.

The first five editions employed the Birmingham (English) Revision of the B.N.A. terminology. American anatomists retained the B.N.A. nomenclature. Consequently the use of Grant's text in medical schools in the States entailed some translation of terms. Recently both English and American anatomists have agreed to the new international anatomical nomenclature or N.A.P. (Nomina Anatomica Parisiensia). The use of N.A.P. terminology in the 6th. edition of "A Method of Anatomy" makes it even more acceptable in the field of gross anatomy textbooks.

The Physician who wishes to refresh his anatomical memory will find this volume both interesting and enjoyable.

Arch E. Cole
Professor of Anatomy
University of Louisville
School of Medicine



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Investigator

after investigator reports

Wilkins, R. W.: New England J. Med. **257:1026**, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. **166:137**, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension," Hollander, W. and Wilkins, R. W.: Boston Med. Quart. **8:** , September, 1957.

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PUBLIC HEALTH PAGE

Poliomyelitis – 1958*

RUSSELL E. TEAGUE, M.D.
Commissioner of Health,
Commonwealth of Kentucky

The Kentucky State Department of Health, in cooperation with the United States Public Health Service, is conducting a polio surveillance program for the second consecutive year. This program is designed to evaluate the efficiency of the polio immunization program throughout the country. All reported cases of poliomyelitis, both paralytic and non-paralytic, are investigated as to extent of paralysis (if any), vaccination, laboratory diagnosis by viral isolation of the specific type polio virus and clinical evaluation of the patient sixty (60) days after onset of illness.

It has been demonstrated that the incidence of paralytic polio has decreased since the advent of Salk polio vaccine in 1954. One point, however, has constantly concerned public health officials: is this decrease due to immunization or is it just part of the natural pattern of the disease? For the United States 1955 was the latest "peak" year with 13,850 paralytic cases. A marked decrease occurred in 1956 and 1957. For this year the number of paralytic cases in the United States is higher than at the same time last year:

1958—2,722 cases
1957—2,007 cases

The east-north central states have reported the greatest number of cases, including some states adjacent to Kentucky: Indiana, Illinois and Virginia; however, so far (as of November 30, 1958) the cases have continued to decrease in Kentucky, as follows:

Year	Paralytic	Non-Paralytic	Non-Paralytic (Pending Lab)	Unspec.	Total
1954	493	321		9	823
1955	187	227			414
1956	134	112			196
1957	69	38			107
1958	53	12	17		82

Improved laboratory methods of virus isolation, complement fixation, neutralization have permitted differentiation of the aseptic meningitides and non-paralytic polio. Present data indicate the following enteroviruses as probable etiological agents in paralytic illness resembling polio:

Coxsackie: A-7, A-9, B-3, 4-B
ECHO 2, ECHO 4, ECHO 6, ECHO 9 and ECHO 16

Three reported cases of non-paralytic polio and one reported case of paralytic polio in Kentucky have been proved in the laboratory to be Coxsackie infections.

In order to evaluate the effectiveness of the polio vaccine program in Kentucky, records of immunizations are obtained on all reported cases. The data are then broken down as follows:

VACCINATED			NOT VACCINATED
1 dose ..... 5 2 doses ..... 5 3 doses 8	18		35
1 dose ..... 0 2 doses ..... 2 3 doses 6	8		4

With the above breakdown it can be seen that the efficiency rate of the vaccine program in Kentucky, based on three (3) doses, is about 85%. This is higher than the national average, which now places the efficiency at about 75-76% (originally it was thought to be about 96% effective). From this can be seen the value of the surveillance program. It may also alter the present program of vaccination to include a booster dose every one to two years.

As stated previously, the majority of cases have occurred in the northeastern states in a triangular area extending from Michigan to New York to Virginia. One western Virginia county bordering on eastern Kentucky has had an "epidemic" of polio and this has apparently spread into Kentucky.

Most of the Kentucky cases have occurred in the eastern counties, with the highest case rate in Letcher County. To date this year, thirty-five (35) cases of paralytic polio occurred in unvaccinated individuals. With the preceding efficiency rate, we see that thirty-one (31) of these could have been prevented by the triple-dose immunization. Polio vaccine, however, is no longer available through the State Department of Health and is available in county health departments only where local funds are adequate for its purchase. The burden of polio prevention, therefore, falls even more heavily upon the private physician.

*See the Special Article on poliomyelitis which appears on pages 66-68.



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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

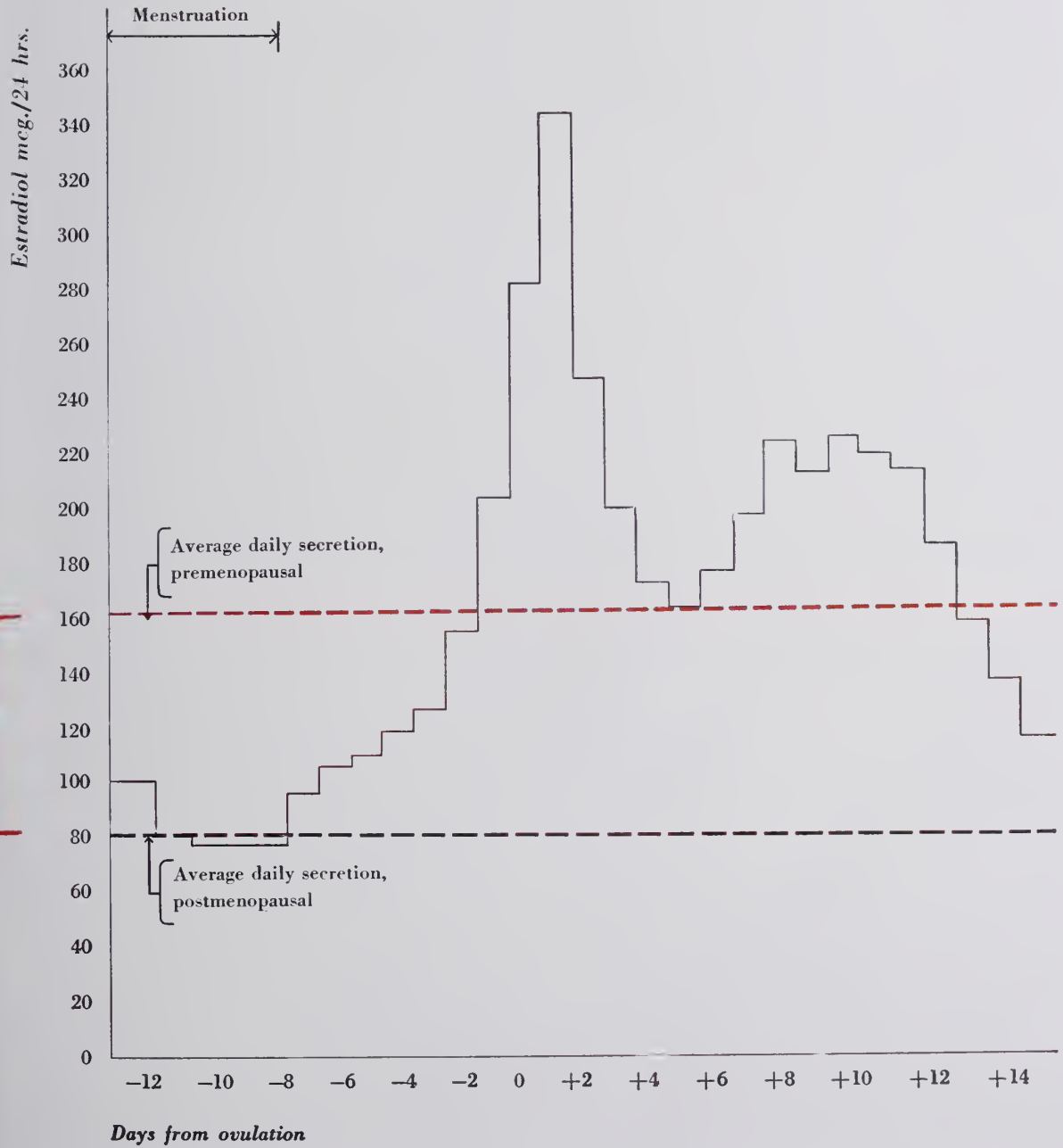
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

Upjohn

*TRADEMARK, REG. U. S. PAT. OFF.

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Endogenous estrogen secretion (mcg./24 hours) (calculated from average 24-hour urinary excretion of estradiol, estrone, and estriol)



From the Files of the

Committee for the Study of Maternal Mortality

CASE #31: The patient was a 42-year-old married white gravida 17, para 17. She was seen initially in her fifth month with this pregnancy and returned for three other visits. By menses she was due November 19, 1957.

Month of Pregnancy

	5th	6th	7th	8th	9th
Blood pressure	110/70	80/60	100/60		110/70
Weight	131	134	138		
Urine	neg	neg	neg		neg

She was Rh+, the VDRL was non-reactive and her Hb on the last visit was 80%, red blood cells 3,750,000. Her past history was significant in that with her last two deliveries in 1955 and 1956, difficulty was encountered wth the delivery of the placenta and the patient bled excessively during the third stage. No mention was made of how many transfusions she received.

The patient entered labor spontaneously November 11, 1957. The first stage of labor lasted 4½ hours. The membranes ruptured spontaneously and the patient had 50 mg of demerol premedication. The second stage lasted 15 minutes. No mention was made of the type of anesthetic, but she delivered spontaneously a 7 pound, 9 ounce girl at 6:31 P.M. The third stage lasted 20 minutes. She started bleeding more than normal a half to one hour after delivery. She was transfused, receiving a total of five pints of blood throughout this day, in addition to this levophed was given to maintain her blood pressure. No mention was made of the cause of the excessive bleeding. The uterus was packed. Nevertheless, it was about 15 hours before she quit bleeding.

The next morning it was noted the patient had no urinary output. No mention was made of her average blood pressure. The patient was typed as 0 positive and all the blood used seemed compatible in the cross match, however, it wasn't stated if a Coombs test was done with the cross match.

A diagnosis of lower nephron nephrosis was made and consultation was obtained. The patient was given 2000 cc 5% G/W and 500 cc saline i.v., first postpartum day.

The catheterized urinary output for the 24 hours was 200 cc. Her subsequent intake was reduced to 1000 cc of 5% G/W daily. In spite of this therapy she failed to improve so she was transferred to another hospital November 15, on her fourth postpartum day. At this time she was drowsy, intensely jaundiced and the achilles reflexes were absent. She was retyped and found to be group 0, Rh neg. and the direct Coombs was positive. The antibodies were demonstrated in the patient's serum by saline, albumin and Coombs procedures. The previous diagnosis was confirmed that this represented a hemolytic transfusion reaction from the Rh+ blood. Since she failed to respond to previous therapy the artificial kidney was used.

Blood chemistry	Before	After	Normal
BuN	145 mgm%	42.8	10-15 mgm %
CO_2	50 vol%	48 vol%	45-69%
Potassium	7.7 meq	5.2 meq	4.6-5.6 meq
Hematocrite	22	30	

She showed some improvement, but she remained icteric and never had a urinary output over 200 cc per 24 hours. A second dialysis was done 11-21-57. There was some subsequent improvement in her sensorium as well as the blood chemistries, but not in the urinary output.

She developed edema 11-26-57 and convulsed, despite restriction of fluids to 600-800 cc daily, and a third dialysis. She developed a deepening depression with slowing of breathing and expired 11-29-57, the 18th day of oliguria, still jaundiced. The cause of death was uremia, due to lower nephron nephrosis, due to hemolytic transfusion reaction associated with the postpartum hemorrhage. There was no autopsy. Comment: This was the second recognized maternal death in Kentucky resulting from the administration of incompatible blood for 1957. Certainly the availability of blood has been life saving on repeated occasions, but to lose a mother through a preventable error should remind us that Dr. De Lee's admonition "Save Blood" is still important. Information was not given as to the source of the prolonged uterine bleeding, merely that it lasted 15 hours. We do not know the patient's general condition

(Continued on page 82)

SAFETY FIRST



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Erythrocin®

STEARATE (ERYTHROMYCIN STEARATE, ABBOTT)

AFTER SIX YEARS, A SAFETY RECORD UNMATCHED IN SYSTEMIC ANTIBIOTIC THERAPY—PLUS REMARKABLE EFFECTIVENESS AGAINST THE COCCI

Actually, after all this time, there has not been a single, serious reaction to ERYTHROCIN. Also, the problem of resistance has remained unusually low.

You'll find ERYTHROCIN highly effective against most coccal organisms. And it may well be the tool to counteract coccal complications following viral attacks.

Usual adult dose is 250 mg. four times daily. Dosage for children may be reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also available in tasty, cinnamon-flavored oral suspension; comes in 75-cc. bottles.

Abbott

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SAFETY FIRST

IN ANTIBIOTIC THERAPY





running noses  and open stuffed noses orally

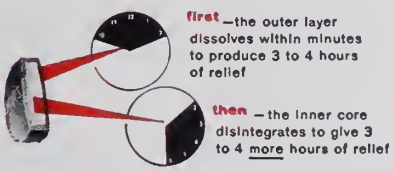
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each TRIAMINIC *Tablet provides:*

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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SPONTIN IN SERIOUS

A Special Report from Abbott
to the Medical Profession
on a Year's Clinical Experience
with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Sy posium in Washington, D. C., a panel of leading antibiotic experts placed SPONT at the top of all other commercially-availal antibiotics for treating serious staphylococ infections. Also, six papers—all dealing with t effectiveness of ristocetin (SPONTIN®) in treati staphylococcal infections—were presented at t Symposium.

One of the most encouraging aspects of t year's literature on SPONTIN is the increasi testimony to its safety. As the months ha passed and cases have accumulated by the hu dreds, it has become apparent that careful att tion to dosage recommendations has practica eliminated toxicity and side effects as seric obstacles to therapy. Also, recent improveme have been made in the manufacture of SPONT the drug is now made from pure crystals.

A recent report[4] in the Journal of the Am can Medical Association concluded, "It is opinion that, if proper precautions are observ ristocetin is a [well tolerated] and potent ag to employ in the treatment of staphylococ infections." And in another study, after succe fully treating 28 patients with a variety staphylococcal infections, the authors reporte "No serious complications were noted."

Few more dramatic records have been writ in such a short space of time. SPONTIN has pro itself to be a good answer, perhaps the b answer at present, to the resistant staphylococ problem—and of real value in other seri coccal infections. It may well be your ans when you're confronted with a serious infection.

Abbo

901066

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

ontin In Treating Severe Respiratory Infections – In 13 of 20 patients the results were excellent, th clinical response being evident within one to ır days after institution of therapy. In three addinal patients, there was some degree of improvent in pneumonic processes superimposed on berculosis in two cases and on pulmonary neoism in one. In all other cases, serious antecedent thology undoubtedly influenced the negative or uivocal response to ristocetin therapy.[6]"

ontin In Treating Staphylococcal Infections—After cessfully treating 28 patients, the authors wrote, istocetin or Spontin has proved to be bactericidal d bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many ier antibiotics.[5]"

ontin In Treating Seven Difficult Cases – "Ristoin has produced excellent results in eradicating, tigating or preventing infection in seven selected ficult cases. Six of the seven cases involved *phylococcus aureus* which did not respond to motherapy with other antibiotics.[7]"

ontin Blood Levels In Children – "Ristocetin was ministered as a single intravenous injection of 5 milligrams per kilogram. This resulted in um levels ranging from 1.3 to 10.6 mcg. after hours with a gradual fall to a level of 0.7 mcg. cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia –"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults – "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
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4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
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10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

even when the causative organism may be a "persistent staph"

Cosa-Signemycin*

GLUCOSAMINE-POTENTIATED TETRACYCLINE WITH TRIACETYLOLEANDOMYCIN

increases the certainty of safe, rapid response

AS PROVED BY extensive clinical trials—an over-all success rate of more than 94% was achieved in a total of 3,280 cases.†

AS PROVED BY success in mixed infections—more than 95% of 1,000 acute and chronic respiratory tract infections were successfully treated; a 99% cure rate was achieved in mixed bacterial pneumonias.†

AS PROVED BY effectiveness in "problem infections"—a response rate better than 96% was recorded in a group of 221 gastrointestinal infections including chronic intestinal amebiasis; 91% of 465 urogenital infections were successfully controlled.†

AS PROVED BY excellent safety record—extremely well tolerated; discontinuance of medication was necessary in only 11 of 3,280 patients.†

A significant number of the above cases had not responded to other antibiotics.

Cosa-Signemycin is particularly valuable in home and office, where susceptibility testing is difficult or impractical.

SUPPLY: *Capsules* (green and white), 250 mg. and 125 mg.
New Oral Suspension (raspberry-flavored), 2 oz. bottle, 125 mg. per teaspoonful (5 cc.).
New Pediatric Drops (raspberry-flavored), 10cc. bottle, 5 mg. per drop, plastic calibrated dropper.

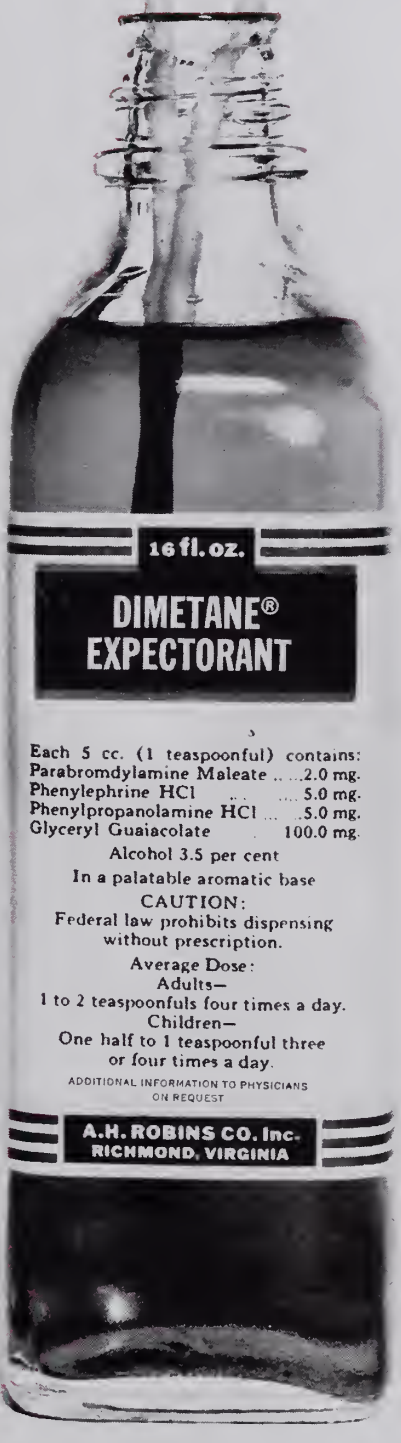
Average dosage: For adults, 1-2 Gm. daily in divided doses; proportionately less for children, depending on age, weight, and severity of infection.

†Literature and bibliography available on request.

*Trademark

Pfizer *Science for the world's well-being* **PFIZER LABORATORIES**, *Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

new for cough



tastes good

the straws just symbolize the good flavor! And DIMETANE EXPECTORANT for cough is as effective as it is delicious. FORMULA: each 5 cc. (1 teaspoonful) contains: DIMETANE (Parabromdylamine Maleate) 2.0 mg.; Glyceryl Guaiacolate 100.0 mg.; Phenylephrine Hydrochloride, USP 5.0 mg.; Phenylpropanolamine Hydrochloride, NNR 5.0 mg.; Alcohol 3.5% in a good-tasting aromatic base.

works better

combines the unsurpassed antihistamine Dimetane with the clinically proven expectorant glyceryl guaiacolate (which increases R.T.F. almost 200%) and two recognized decongestants. When additional cough suppressant action is indicated, prescribe DIMETANE EXPECTORANT-DC, which provides the basic formula with dihydrocodeinone bitartrate 1.8 mg. per 5 cc. (exempt narcotic).

Dimetane® Expectorant
Dimetane® Expectorant-DC

Robins

(WITH DIHYDROCODEINONE BITARTRATE 1.8 MG./5CC.)



WASHINGTON NEWS DIGEST



Washington, D. C.—It is now well-recognized that the new 86th Congress, heavily spiced with newly-elected Democratic liberals, will set out to make an impressive record for itself. Health legislation will not be neglected.

On the basis of developments last session, and the known interests of many of the new members of Senate and House, here are the health areas where intensive activity is assured, with prospects for enactment of a number of bills either this year or next year, the final session of the 86th and also a presidential election year:

Social Security. Labor has announced that it will work this year for substantial changes in social security, the most important being a program for hospital-nursing home care for the aged and other beneficiaries. On this the unions are supported by the Democratic Advisory Council, which reflects the views of the Truman-Stevenson-Butler element of the party but generally finds itself to the left of Senator Leader Johnson, House Speaker Rayburn and some other Congressional leaders.

Under social security, the AFL-CIO and the Democratic Council also would lower or drop the age 50 requirement for disability payments, increase the OASI taxes, bring more income under the taxes, and raise benefits all up and down the line.

American Medical Association, joined by scores of other associations and individuals in health and other activities, successfully opposed the social security hospitalization plan last session. They are prepared to wage just as determined a fight this year.

Aid to Medical Schools. An effort was made in Congress last session to provide grants to medical schools for building and equipping teaching facilities, to complement the research grants program already in effect. While the administration supported the attempt, it did not throw behind it all the energy it is expected to exert this year. Top officials of the Department of Health, Education, and Welfare, from Secretary Flemming on down, have been talking up aid to medical schools all fall. When time comes to testify, they will be strengthened by the activities of a new committee appointed to look into the schools' problems, as well as by the Bayne-Jones report which calls for the immediate start on construction of between 14 and 20 medical schools.

American Medical Association supports construction and equipment grants for medical teaching facilities. Strongest opposition this year is likely to come from some influential members of Congress, who succeeded in bottling up the legislation last session.

The Keogh bill. Last session this legislation to permit the self-employed to pay taxes on money withdrawn from retirement funds passed the House but failed to get out of committee in the Senate. Its sponsors, including the AMA, are hopeful that the Senate objections can be removed this year.

Medicare. Congressmen already have received protests from back home about restrictions imposed on the civilian phase of Medicare, mostly the channeling of service families to military facilities. This issue is sure to come up when appropriations hearings start on the Defense Department's budget. It may come up sooner, if Medicare runs out of money and requires a deficiency appropriation.

The Doctor Draft. The special draft, which hasn't actually been used in two years, may be invoked by the Defense Department this spring, if there isn't a better response on the part of interns and residents to the appeals for volunteers. Should the law have to be used this year, the Defense Department will have a pretty convincing argument that it should be extended beyond its scheduled expiration date of next June 30.

Medical Research. While the Federal government currently is spending at a rate of more than $324 million on medical research through the National Institutes of Health, a still higher record of appropriations is in prospect for next year. The Senate Appropriations Committee has announced that never again will the pace of research be slowed through lack of dollars. This is also the attitude of the AFL-CIO and the Democratic Advisory Council, among other groups. The pattern usually is for the House to increase moderately Budget Bureau figures for medical research, then for the Senate to vote large additional increases. The House then generally agrees to spend close to what the Senate wants.

Contributory Health Insurance for Federal Workers. A new effort to bring about a contributory health insurance program for civilian federal workers is expected, with federal employee unions leading the drive.

Other Prospects. A number of amendments will be proposed for the Hill-Burton act. Some effort will be made to strengthen the law under which labor-management health and welfare funds must keep records and file reports. Hospitals are looking forward to low-cost loans under a community facilities bill and nursing homes to mortgage guarantees. The feud over VA's closing of 5,000 beds likely will be renewed.



Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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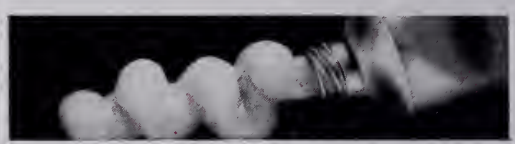
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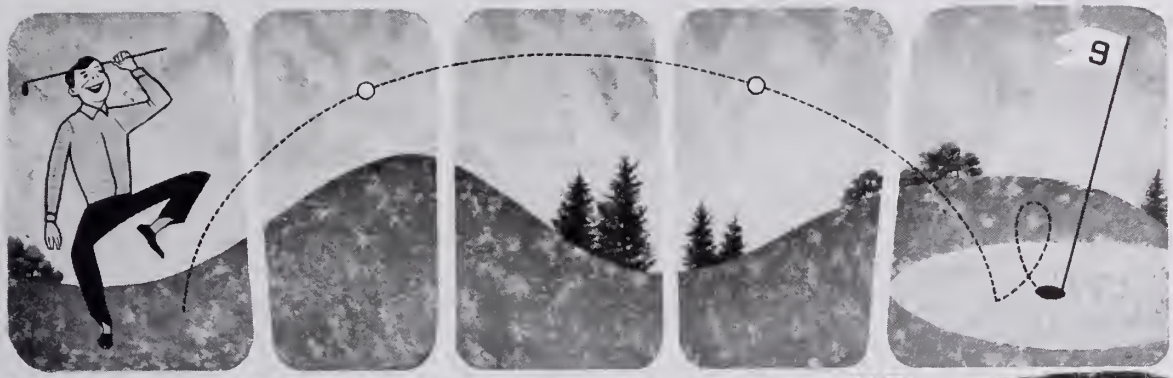
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- effective for 6 hours or longer • promotes expectoration
- rarely constipates • cherry-flavored

Each teaspoonful (5 cc.) contains:

Hycodan®		
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
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Pyrilamine Maleate		12.5 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Supplied: as a pleasant-to-take syrup. May be habit-forming.
Federal law permits oral prescription.

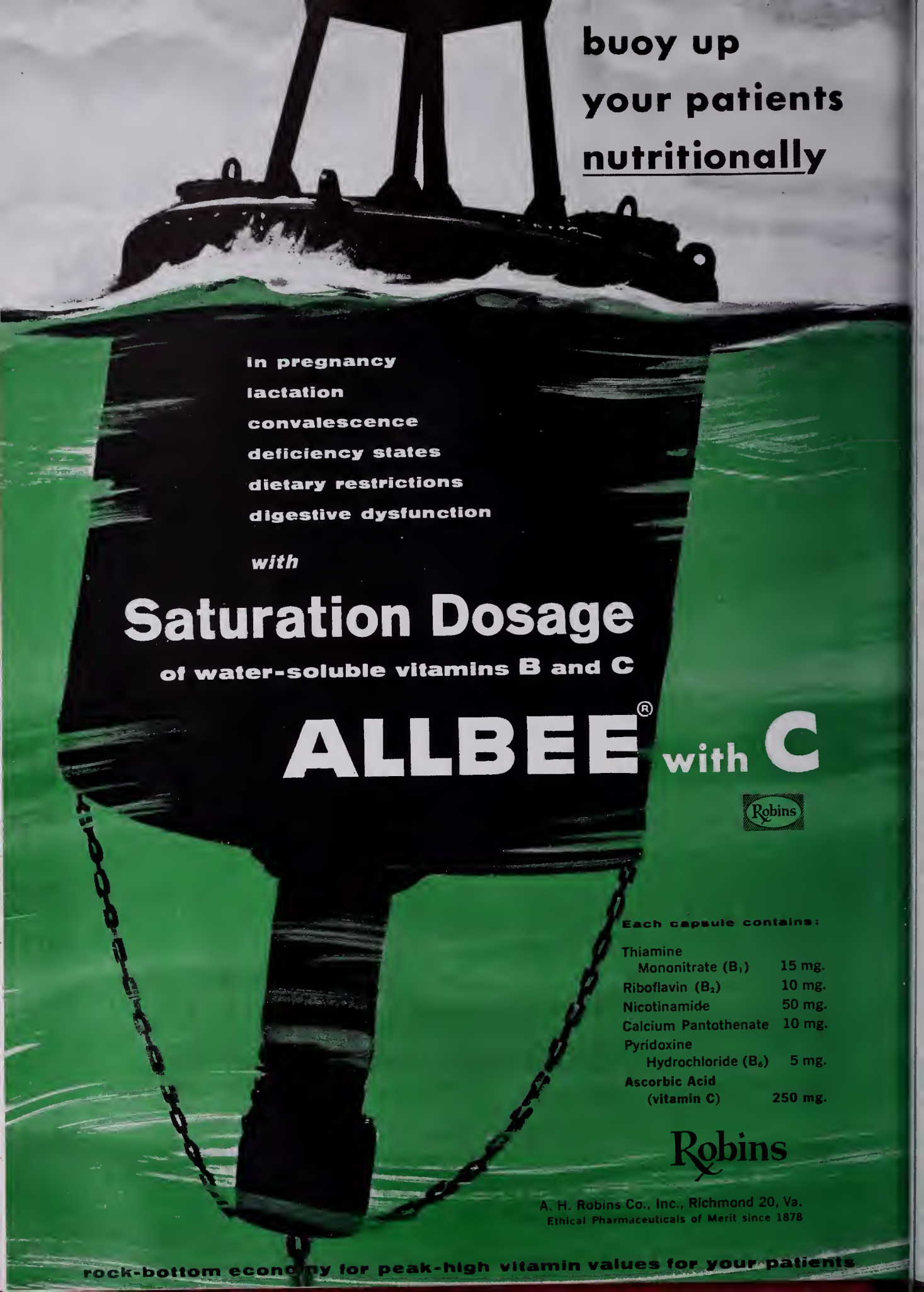
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rock-bottom economy for peak-high vitamin values for your patients

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A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

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PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

VISTARIL Capsules: *25 mg., 50 mg., 100 mg.*

VISTARIL Parenteral Solution: *10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).*



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2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

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CHLOR-TRIMETON® Maleate (chlorprophenpyridamine maleate)	4 mg.
Salicylamide	0.19 Gm.
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Caffeine	30 mg.
Ascorbic acid	50 mg.
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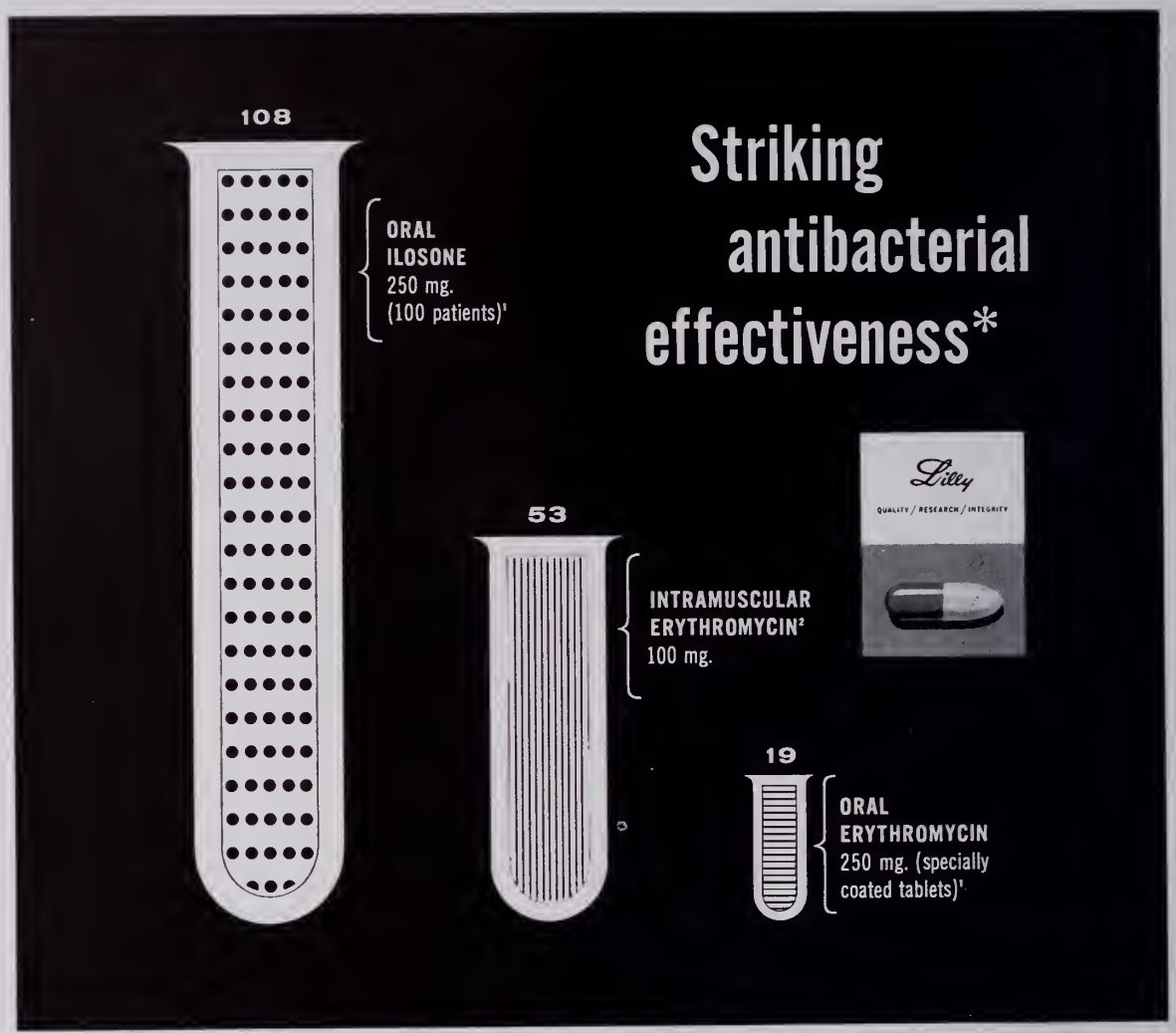
Dosage—1 capsule q. 4-6.

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1. Griffith, R. S., *et al.*: Antibiotic Med. & Clin. Therapy, 5:609 (October), 1958. Note: Peak levels with the oral erythromycin tablets (thirty-three dilutions) were not observed until four hours after administration. 2. Data from Griffith, R. S.: Antibiotics Annual, p. 269, 1954-1955.

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Recent Trends in the Surgery of Diverticulitis*

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THERE are three main reasons why the subject of diverticulitis can and should be reopened, and why it has become, once again, a field in which one should "take inventory" frequently:

1) The aging of our population, which makes diverticulitis a problem that surgeons face much more often than in the past;

2) An increasing awareness of the degree of invalidism that often accompanies prolonged conservative treatment in these cases even if disaster does not strike; and

3) The increased safety of major colonic surgery, due to many well-known factors.

Our knowledge of diverticulitis, in contrast to that of most problems in abdominal surgery, goes back only to the relatively recent past. Although Cruveilhier described colonic diverticula in 1849 and Habarshon published the first account of diverticulitis in 1857, very little of practical importance came along until Edwin Beer's comprehensive treatise in 1904. Furthermore, it was only 50 years ago that William J. Mayo reported five resections of the sigmoid for "tumors" that turned out to be due to diverticulitis, the first such series reported.

But, rather than spend too much time on the past, let us get on to the present. The increase in life expectancy is what has made the problems associated with diverticulitis challenging once again. We are told that in 1900, only one person out of 25 in this country was 65 years old or older, that the present figure is one in twelve, and that in 1975, the estimated comparable figure will be one in seven. This aging of the population has contributed greatly to the increased interest in diverticula of the colon and the ills to which they may lead.

Incidence

Diverticulosis is common indeed. Bargen reported an incidence of 5.2 per cent in a total of some 70,000 autopsies. At the Massachusetts General Hospital, approximately one-third of the patients who have barium enema studies show diverticulosis of the colon, and one-tenth show evidence of diverticulitis. Diverticulitis is rare below the age of 45, the incidence rising markedly with each subsequent decade. Of nearly 2,000 patients with diverticulitis reported from a large clinic, only 20 were under 40 years of age.

It is particularly with the inflammatory consequences that we are concerned, for diverticulosis, as such, is a peaceful disease, of which the host is likely to be quite unaware. Furthermore, the milder manifestations of actual diverticulitis are likely to be transient and more or less self-limited. As for the severe complications of diverticulitis, surgeons are beginning to realize that they must treat them more aggressively and thereby save many patients from semi-invalidism.

Some 24 years ago, my old chief, Dr. David Cheever, in discussing an excellent paper by the late Dr. Irvin Abell, Sr., covered this matter in his own unique style: "Multiple acquired diverticula of the colon . . . are always potential and often actual foci of acute and chronic infection . . . (and) . . . merit the attention of every physician, not as rarities but as frequent sources of serious conditions. From a state of complete innocuousness, they range through symptoms of every grade of severity to conditions so grave that they defy the surgeon's skill." Dr. Cheever spoke of nearly all the

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varieties of diverticulitis that one could think of, including what he called "simple diverticulitis." He mentioned slow perforation with adhesions and abscess, the formation of fistulous openings into the bladder or into other loops of the intestinal canal, free perforation with spreading peritonitis, and chronic inflammation with fibrotic thickening that ultimately leads to obstruction. It is interesting that he did not mention bleeding in connection with diverticula, a controversial matter that we will get to presently. Neither did he mention small bowel obstruction due to secondary involvement of contiguous small intestinal loops in the area of the diverticulitis, a rare but important event. Another fascinating feature of some neglected cases is the amazing burrowing ability of abscesses due to diverticulitis. On two occasions, I have seen such abscesses drain spontaneously through the cervical canal, in patients who had had a supracervical hysterectomy many years before.

Indications for Surgery

The most important addition to Dr. Cheever's list of indications for surgery, in my opinion, is failure of conservative treatment to make the patient comfortable, even in the absence of the more dramatic complications. I suppose we might call this failure to respond "intractability." The dictionary prefers "intractableness." "Obstinacy" would seem simpler. At any rate, the term "intractable" is usually applied in surgery to certain peptic ulcers; and this brings us to the point that the indications for surgery are really just about the same in diverticulitis as in peptic ulcer—acute and chronic perforation, hemorrhage, obstruction, failure to respond to medical management (if the severity is sufficient to interfere with the patient's normal life), and (in the case of gastric ulcer) difficulty in ruling out carcinoma. Most of these indications are rather obvious, but some require special comment.

The late Dr. Arthur Allen (a beloved Kentuckian better known as "Jimmy" Allen), described, in a carefully detailed report covering an 11-year period, 114 patients who had resection of the sigmoid for diverticulitis. This group represented about one-fifth of all patients with diverticulitis seen during that period. He compared this series with a series of patients previously reported from the same hospital, many of whom were operated on by the same surgeons. Only 33 resections of the sigmoid for diverticulitis were done in the earlier 16-year period, the patients so treated representing one-tenth of those seen with diverticulitis. Further analysis showed that, in the earlier series, only dire complications led surgeons to resort to surgical treatment; while in the later series, greater safety influenced them to advise resection on a much more liberal basis. The mortality for this later group was 2.6 per cent. My own feeling is that greater inclination to employ resection in these patients is amply justified.

The disease seems, in general, to be more severe in men, perhaps due to the protection against bladder involvement in women, provided by the uterus and broad ligaments. Some of these miserable patients have years of semi-invalidism before surgical treatment brings relief. It is too bad that we cannot have a crystal ball that will tell us, at an early stage of the disease, which patients are not going to respond to conservative measures; for an operation that would have been easy a few months earlier may be difficult indeed when finally resorted to. We must not let this fact lead us to be too aggressive; and it is often hard to decide, in a given case, what one would wish done to one's self in a similar situation. After all, this should always be the basis on which a surgeon gives advice.

In general, it seems likely that about one person in fifteen over 40 years old has diverticula in the colon, that about one-fifth of them will develop diverticulitis in some degree, and that about one-fifth of those with diverticulitis will require resection.

I would like to discuss briefly certain specific problems in the surgery of diverticulitis.

Perforation

Acute "free" perforation into the abdominal cavity is not common, but when it occurs it is a very serious matter. The usual clinical impression is that of fulminating acute appendicitis or rupture of some other hollow viscus. The fact that the sigmoid is often in the midline, or even well to the right of it, may add to the confusion; and the presence of gas under the diaphragm, shown in x-ray studies, may lead the clinician toward a diagnosis of perforated peptic ulcer.

The patient with acute perforation of the sigmoid is likely to be a man, fat, and extremely ill. The site of the perforation (usually sigmoid) may be difficult to find in a large inflam-

matory mass. The tissue will be so friable that attempted closure of the opening by sutures will not be feasible, nor will an attempt to put an omental "patch" over it accomplish much. Drainage must be established (preferably through a small left McBurney incision, rather than through the main exploratory incision). A major decision must be made as to whether or not a proximal vent needs to be established. In all likelihood, this need was not anticipated before operation and the possibility of a colostomy was not discussed with the patient, who is now under general anesthesia. The surgeon is reluctant to do a colostomy without prior permission, especially if he feels that it may not be absolutely necessary. It is obvious, too, that an acute perforation in sigmoidal diverticulitis may be quite a different matter from a penetrating wound of the sigmoid from a missile. However, experience in military surgery has securely established the value of a proximal vent in sigmoidal perforation, and I believe that a divided colostomy in the right side of the transverse colon should be made. Drainage and antibiotic therapy may be enough to get him well; on the other hand, they may not.

If perforation develops more slowly and the inflammatory mass remains localized, "watchful waiting" may be rewarded. Even if a true perisigmoidal abscess has developed, it may drain spontaneously into the bowel and resolve. Unfortunately, however, it may drain into the bladder—and a sigmoidovesical fistula is one of the more miserable and serious complications, uniformly requiring surgical relief. If it becomes necessary to drain an abscess through the abdominal wall (usually through an oblique and more or less extraperitoneal approach), a sigmoidocutaneous fistula is likely to follow. This may persist for weeks, months or years, discharging only a small amount of purulent material and, rarely, feces. It may be only slightly annoying to the owner unless flare-ups occur, which happens occasionally if the exit becomes too small. One point must be emphasized, namely, that no matter how easy dissection would appear to be upon study of the x-ray plates showing the fistulous tract outlined by a radiopaque agent, one must not try to dissect out these fistulous tracts and close the sigmoid opening as one would the stump of an appendix. At operation, the sigmoid wall will not be normal enough to close properly, the "hole" is likely to be on the mesenteric side, there may be narrowing beyond the area, and success is unlikely, and disaster a real possibility. If the chronic fistula is causing enough inconvenience, or if the inflammatory area in the sigmoid flares up repeatedly, resection of the diseased area by a "staged" surgical plan will be indicated.

In the female patient, the pelvic organs (especially the left adnexae), may be involved in a chronic inflammatory mass of sigmoidal origin. Such a situation may be unexpectedly met by the gynecologist who anticipated a mass of adnexal origin, and may present a difficult problem in surgical judgment and management, requiring immediate decision. It also presents a strong argument pointing to the fact that a complete surgical training should be required of anyone who is to open an abdomen. The gynecologist who has not had a thorough general surgical training is greatly handicapped, and so are his patients. It is too bad that many otherwise excellent hospital training programs do not recognize this fact.

Special comment should be made about one group of "perforations" in diverticulitis—those giving rise to sigmoidovesical fistulae. These are not rare. Of 22 consecutive sigmoid resections for diverticulitis, at Roosevelt Hospital, no less than six involved sigmoidovesical fistulae. There is little trouble in persuading such patients to allow preliminary colostomy. The constant urgency and dysuria are miserable companions that clear rapidly after a divided colostomy has been done. Once again, we must mention the danger of confusing diverticulitis with cancer when both are present, and this possibility must be kept constantly in mind. Nearly a third of sigmoidovesical fistulae are caused by cancer, and in many such instances previous or recent x-ray studies may have demonstrated the presence of diverticula. One may thus be easily deceived, and delay the resection too long.

Obstruction

Acute fulminating obstruction of the left colon in older people is likely to be due to cancer or to volvulus, but may occasionally be due to diverticulitis. In diverticulitis, the story is usually a long one, with episodes of repeated subacute obstruction and the gradual narrowing of a long sigmoidal segment from chronic scarring. This, plus edema caused by a new attack, finally creates a situation demanding operation. The proximal colon will appear

edematous and chronically distended and thickened, and these patients usually need a real "defunctioning" operation (divided colostomy) rather than the mere establishment of a "vent."

In a few very ill patients with huge cecal distention confirmed by the roentgenogram, a simple cecostomy will tide the patient over the emergency. (Needless to say, reliance on "long tube" decompression from above, in the presence of a competent ileocecal valve, is the road to disaster.)

It is obvious that prompt resection must be done in those cases in which cancer cannot be ruled out by repeated studies. It is less obvious, but also true, that few patients with partial obstruction due to diverticulitis will do well until resection has been done. Divided colostomy in the right side of the transverse colon will lead to improvement in the condition of the diseased part of the left colon, but restoration of the old situation will mean more than 70 per cent of failures. Resection is ordinarily the wisest course, with due caution exercised in allowing plenty of time between stages.

Cancer of the Sigmoid Associated with Diverticulitis

Mention has already been made of the danger of overlooking a sigmoid cancer when it coexists with diverticulitis. A mass is often felt in patients with either condition; marked tenderness is unusual with a sigmoid neoplasm, but characteristic of diverticulitis. Both conditions are fairly common, and are found to coexist often enough to create a real problem to any X-ray Department and to any busy surgical service. The surgeon must make the diagnosis. Any surgeon who does not carefully study the x-ray plates of his own patients (merely accepting typed reports) is not being fair to them or to himself. When real doubt exists, and the chance of sigmoidal cancer appears definite, the usual waiting period between colostomy and resection must be cut down for obvious reasons. In approximately one out of four cases, doubt still exists as to the presence of cancer at the time of resection of segmental diverticulitis. Those patients who have had repeated bleeding, those with obstruction, those who do not improve properly on medical therapy or after colostomy, and those with x-ray findings not quite typical of diverticulitis must all be suspected of harboring cancer. Eternal vigilance is the price one must pay, if one is to avoid "watching" a sigmoid cancer for many months in the belief that the lesion was inflammatory.

Bleeding

The most controversial item in the list of "Complications of diverticulitis" is that of bleeding. Some outstanding surgeons feel that colonic diverticula are a common and important source of intestinal hemorrhage that may be profuse. Others are highly skeptical, pointing out that such statements are based on exclusion of other usual sources, and that the actual proof of the site of bleeding in these reports is rare indeed.

Four detailed case reports were recently published, as being indicative of bleeding from diverticulosis. One of the patients apparently died of pneumonia after severe rectal bleeding, and no autopsy was allowed. Two had sigmoid resections in which the bleeding point was not demonstrated, although it was thought likely that "engorged granulation tissue" and diverticular "ulceration" were the cause. The fourth had no further bleeding after resection of a portion of sigmoid in which no bleeding point was demonstrated. In the summary, it was stated that in these four cases, "diverticular disease" was the "principal etiologic factor" in the massive bleeding—a statement that would surely imply some doubt about other possible factors. Many such reports are equally unconvincing.

In my own opinion, those who teach young surgeons should repeatedly caution them to be very hesitant about accepting diverticulosis or diverticulitis as the source of important bleeding. Any other attitude will often lead to dangerous delay in finding the real source of bleeding.

It is often stated that "there is a history of bleeding" in many patients with diverticulitis, the usual estimates running between 15 and 30 per cent. One wonders what the figure would be in the entire adult population. Surely one could get a history, in a high percentage of patients, of blood occasionally observed in the toilet over the years.

Of Allen's patients who had sigmoid resection for complications of diverticulitis, five were operated on for hemorrhage, three of whom had "true massive hemorrhage." One patient had diverticulosis involving almost

the entire colon, and bleeding recurred after sigmoid resection. Bleeding did not recur after removal of the rest of the colon. An ileoproctostomy was done, diverticula being absent from the rectum, as is usually and fortunately the case.

In a talk before the Southern Surgical Association, three years ago, Dr. Rudolf Noer made an excellent contribution to our understanding of bleeding as a complication of colonic diverticula. His transparency preparations of injected specimens have made a great contribution to our knowledge of diverticula and the blood vessels that intimately surround them.

It so happens that the few patients I have seen, in whom I felt sure that colonic diverticula were the source of major hemorrhage, were nearly all elderly men; and in no case was there clinical evidence of diverticulitis. The diverticula, in these cases, were many and rather large.

Surgical Management

The increased safety of partial colectomy for diverticulitis, in recent years, stems from improvements in the methods of anesthesia and preoperative and postoperative care, from antibiotics, and from better technical surgery. In spite of all this, this is a field in which one can easily stumble, and one in which caution and a certain amount of timidity are still needed.

Preliminary Colostomy

When resection of the badly diseased segment of sigmoid is necessary, whether for acute or subacute perforation, for fistula or sinus formation, for stubborn infection that persists in the wall and mesentery of the sigmoid, or for obstruction in varying degree, the question of preliminary colostomy must be settled first. The present trend to one-stage resection is strong. Of Allen's 114 resections, 40 were done in one stage. With careful selection of cases, preparation, and after-care, one can do these resections in one stage with a respectable mortality. The patient and the family are always grateful for the avoidance of a colostomy. However, one must not allow the desire to avoid a colostomy to lead to a course of action that will harm the patient, perhaps with fatal outcome. One-stage procedures are now feasible but only in favorable cases. The early report of Pemberton and his associates on nearly 400 patients with diverticulitis, who required operation, is most impressive. In the early series, the mortality of resection was 14.7 per cent, while in a series of 144 patients operated on between 1940 and 1945, the mortality had been lowered to 4.2 per cent. There were many factors in this decline, especially the use of chemotherapy. However, and most important, the mortality in the second series of those patients who had a preliminary colostomy (62 per cent of the resections) was only 1.1 per cent! One can safely assume that colostomy was done in the more severe cases, and it follows that avoidance of a colostomy must have raised the mortality rate in the others.

Since Pemberton's report, further advances in the methods of anesthesia, in antibiotic attack on the intestinal flora, and in supportive measures for the very ill surgical patient have improved the outlook; but I firmly believe that those who try to do more and more colon resections (for diverticulitis) in one stage will regret it. Rather convincing statements are found in the surgical literature that disagree with this belief.

The choice of operation should depend on the presence or absence of obstruction, the acuteness of the process, the extent of peridiverticulitis (especially in the mesocolon), and the presence or absence of a fistula. When in doubt, a multiple-stage attack should be resorted to. Even when resection and anastomosis are done at the first operation, it is safer to add a cecostomy at the same time. This can be easily done in such a way that the opening will close spontaneously shortly after the tube is removed.

The colostomy should be a completely diverting (divided) one, but the two openings need not be separated by an area of skin, for the simple divided loop will give adequate diversion of fecal content. The colostomy should be made in the transverse colon, and should ordinarily be made on the right side of the abdomen. Many of the subsequent resections will involve complete mobilization of the splenic flexure, and a colostomy on the left side (though more convenient to manage) may handicap the surgeon at the next stage. Only in cases where the involved segment is short should one consider this type of colostomy. The daily left colostomy enema is a far simpler

routine than the use of a suitable bag on a right-side colostomy with liquid content. However, such a procedure is rarely applicable to diverticulitis victims that need resection.

The colostomy will bring prompt improvement in the condition of the diseased portion of the left colon, in most cases. In a few, the improvement is slower and less marked. If this is the case, look out, for associated carcinoma is a strong possibility! There is always a temptation to close the colostomy too soon if resection is not contemplated, or to do the resection too soon if this is the planned procedure. Re-establishment of the fecal stream, without first removing the diseased segment of the sigmoid, is ordinarily the road to disappointment. Only one-third of Pemberton's patients (even after the left colon had been relieved of traffic for six to twelve months) did well after closure of the colostomy without resection. It is a sound policy to proceed with planned resection in those cases that were subjected to colostomy. Exceptions to this rule might be found largely in those patients who have suffered acute free perforations with little history of previous trouble, and have had emergency right colostomy plus drainage to the site of perforation.

The interval between the colostomy and the resection should be at least three months, with a wait of six months (or even longer) preferable in most cases. It must again be emphasized here that this rule does not apply in those cases of diverticulitis in which carcinoma is suspected. In a definite proportion, the presence of carcinoma cannot be ruled out completely by clinical study or repeated x-ray studies. Even when the resected lesion is in the surgeon's hand, it may still be hard to decide as to its nature; but when the pathologist divides the mass that is due to diverticulitis, it springs apart; and it then becomes apparent that the old and new inflammatory changes are in the layers outside the mucosa. The mucosa itself always looks surprisingly normal, usually entirely normal (even in long-standing disease), except for the small entrances to the diverticula.

The resection must be done with care, and usually requires complete mobilization of the splenic flexure. The management of the thickened diseased mesocolon is tedious, but the process usually stops a few centimeters above the pouch of Douglas, and one can spare the superior hemorrhoidal artery. As I have already mentioned, for some reason, diverticula do not occur in the rectum below the peritoneal reflection. The badly diseased bowel must *all* be removed, so that the ends to be anastomosed will be in good condition. Those surgeons who tend to remove longer segments get better results by doing so. Adequate removal of bowel is made possible by thorough proximal mobilization. The transverse colon can be brought down almost to the level of the pouch of Douglas, if need be. A few diverticula are often left in the remaining portion of the colon, but if these are soft and quiet, and the anastomosis is adequate in size, they will probably cause no harm. In other words, one must remove all the segment that was involved in diverticulitis, but some scattered areas of diverticulosis can safely be left in. The anastomosis is done as an "open" procedure, end-to-end.

Closure of the Colostomy

After the resection and anastomosis, the patient and the surgeon are anxious to get to the colostomy closure. Here again, one is tempted to save time and expense and further "colostomy nuisance." We can usually "get by" with closure in ten days, but a delay of four to six weeks is wiser. If in doubt, x-ray studies with thin barium carefully administered will give a good idea of the condition of the left colon with its recent anastomosis.

One must urge the X-ray Department to be very cautious in handling these diverticulitis patients, both before and after operation. The current great enthusiasm for air-contrast studies in investigation of the colon, (especially if there is a history of bleeding) leads to the real danger of blowing out one or more diverticula —we have had this happen.

One last word about the trend toward one-stage resections. I have a close friend who does nearly all these resections in one stage, even if there is a sigmoidovesical fistula; and I must confess that I recently did a one-stage resection (on a thin patient) in spite of the presence of an abscess, and she proceeded to have an unusually smooth recovery. We must not get too gay, however, with this one-stage business, or we will regret it. In Dr. Waugh's series of 93 one-stage resections, there was only one death (and that due to massive hemor-

rhage from a duodenal ulcer), but these cases represented only 29 per cent of the resections done during the period. In other words, Dr. Waugh's fine record was due not only to surgical skill but to careful selection of cases and suitable caution toward the one-stage solution of the problem.

A very important factor in deciding on the surgical plan is the physical type of the patient. Dr. Lahey once remarked that surgeons should estimate their fees on the same basis as the Express Company—so much for the first 100 pounds and so much for each additional 10 pounds! Obesity, and many of these diverticulitis patients are fat, is surely one great enemy of the surgeon, as well as of the patient.

Now, a few brief comments about surgical management when the indications for resection are present. I have outlined some of the factors that allow one-stage resections, and others that demand multiple - stage procedures. In either case, resection must be preceded by mechanical cleansing of the colon. Fleet's Phospho-soda Solution, in repeated dosage, is used, if the colon is in continuity—gentle and cautious warm saline irrigations, if it has been divided. Less important is antibiotic preparation, although we usually use 10 gm. of neomycin, given over a 36- or 48-hour-period. In many cases, technical difficulties rather than infection, try the soul of the surgeon. The mesentery may be stiff and brittle, as are its blood vessels, and it may contain residual abscesses. Hemostasis may be extremely difficult. In such cases, one wishes that a longer interval between stages had been allowed; but, even then, many cases would remain tedious and difficult.

For the actual anastomosis, the bowel ends must be normal or *almost* normal, and this may mean anastomosis of the splenic flexure, at a point very close to the pouch of Douglas. Complete avoidance of tension is, of course, mandatory. We usually use only one posterior row (because the meso-rectum area has no peritoneal layer to help us), with interrupted chromic "Double-O," including all the layers, with the knots on the lumen side. On the anterior surface, we add a row of fine silk. At one time, we usually passed a rectal tube up through the anastomosis, but this often served more as a cork than as a vent, and we abandoned the use of the tube long ago. We do put soft rubber drains to the bottom of the pelvis, which often cannot be properly covered with peritoneum.

Summary

The great increase in life expectancy means that surgeons will be faced more and more with the problem of diverticulitis and its major complications. Furthermore, our better understanding of the invalidism that may plague these patients (even in the absence of dramatic complications) has liberalized the indications for curative surgery.

The lowered risk of resections of the sigmoid makes diverticulitis an increasingly satisfactory field of surgical endeavor. This increased safety is due to many factors.

One-stage operations are convenient for the patient and tempting for the surgeon, but we should still do multiple-stage operations when in doubt.

Few busy doctors will fail, at some time, to treat a carcinoma of the sigmoid as diverticulitis until it is too late to do much about it. We must be eternally vigilant if we are to avoid this pitfall.

Major bleeding from diverticulosis is rare, but does occur. We must teach our Surgical Residents to have a healthy skepticism about this, and to seek other causes. We should also try to teach them that the plural is "diverticula" instead of "diverticuli"—this is important only in that it is correct!

We must also teach the X-ray Departments that their currently-favored methods of studying the colon may find the thin diverticula unable to withstand the mechanical strain, and that the consequences may be serious.

Some Errors Of Omission And Commission Which Lead To Repeated Gynecologic Surgery*

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IN the last fifteen years, great stress has been put on the desirability of doing conservative operations on the female pelvic viscera. With this concept I thoroughly agree. However, one first must determine what is and what is not conservative surgery in the individual patient.

There are too many repeated operations on the pelvic viscera of the female. This would indicate that either incomplete operations are being done, or inadequate surgical judgment is being used. Perhaps the great stress on conservation is playing a part in causing some of the repeated operations. Other causes seem to be incomplete examination and evaluation of the patient in the preoperative period. Still other repeated operations seem to be the result of omissions at the time of operation. Some of the remarks to be made in this paper may seem, at first glance, to be rather radical. I believe that these seemingly radical ideas are justified. I will present cases to illustrate the points advanced.

Endometriosis

One of the most puzzling diseases to treat surgically is endometriosis. In many cases repeated operations are done and with perfect justification. Certainly a young woman with endometriosis who is being disabled five to ten days a month should be operated on, and if children are desired a conservative procedure should be done. The amount and severity of symptoms vary greatly in women who have endometriosis. Many of these patients may have extensive disease and yet have no or only minimal trouble; others who have minimal involvement may be severely disabled. There is no reason to operate on the ones without symptoms unless there is a persistent large cyst or unless sterility is a problem. Those who have severe dysmenorrhea, dyspareunia, and a retrodisplaced, fixed fundus and who desire children should have a conservative procedure done. Every effort should be made to give these patients a chance for pregnancy. In older women who do not desire children, a total hysterectomy with double salpingo-oophorectomy should be done. If disabling trouble recurs in the younger women desiring children, I believe that hysterectomy should be done and probably all functional ovarian tissue removed instead of piecemeal removal at intervals of every few years, as is seen in many instances.

These women can be maintained on small doses of estrogen without difficulty. They can adopt children if they wish and rear them for several years on the energy, time and money that they would have spent trying by repeated conservative operations to beget children of their own. If one good, conservative, corrective operation does not result in fertility, it is extremely unlikely that further procedures will succeed. Obviously, thorough study should be carried out to determine for sure that these women are sterile before hysterectomy or other permanently sterilizing procedure is carried out.

Case Report

The following is a case report of a 26-year-old woman whom I first saw in 1952. She complained of almost constant dull discomfort in the pelvis, which was much worse during her menstrual period.

For the past two or three months, Mrs. W. K. had menstruated twice each month with flooding and clots. She had been operated on in 1945, when one tube and ovary and the appendix had been removed for what she was told was pelvic inflammatory disease. Pelvic examination in 1952 revealed a normal size fundus with a small cyst on the right and an indurated feeling along the floor of the pelvis. She had been taking penicillin off and on for six months, a total of about fifty shots in all. I thought she had endometriosis. An operation was advised but declined by the patient at that time. She was next seen in 1954, two years later, with no essential change except that her periods were more regular.

In November, 1956, she came in seeking relief because of severe pelvic pain at the time of menstruation and continual soreness in the

*Presented at the annual Fall Clinical Conference of the Lexington Clinic on October 25-26, 1957.

lower part of the abdomen. At this time a left ovarian cyst, and a tumor in the wall of the uterus, were palpable. At operation she had multiple small fibroid tumors in the fundus uteri, extensive endometriosis in the pelvis and many endometrial implants in the ovary with a small chocolate cyst of the left ovary. Her remaining female pelvic viscera were removed. Now, eleven months after operation, she says that she cannot see why she waited so long for relief.

This patient was 19 years old in 1945 when one tube and ovary and the appendix were removed. The pathologist's report of the tissue removed at that time is not available to me; but in view of the extensive involvement of remaining pelvic viscera, one would suppose that this condition was only a continuation of what she had when she was operated on in 1945. She was obviously sterile at the second operation as the remaining tube was markedly involved with endometriosis. If an effort had been made to preserve this tube and ovary, the patient would have required another operation, and I am sure that efforts at opening up this tube would have been futile.

Diagnostic Curettage

One of the most helpful procedures in gynecologic surgery, a simple procedure but one which will aid greatly in preventing errors of omission or commission, is the diagnostic curettage. A dilatation and curettage before abdominal hysterectomy will give much information at times. It may reveal an unsuspected adenocarcinoma of the fundus or perhaps other previously unsuspected conditions in the pelvis which will make the contemplated abdominal procedure easier if known before hand. At this time, too, with the patient under anesthesia, the pelvic viscera can be examined carefully, a procedure which may also be very helpful. Entirely unsuspected carcinoma of the cervix may be encountered when a dilatation and curettage is done. The external os of the cervix may appear normal, but the endocervix may be entirely destroyed with only a thin mucous membrane still intact. If hysterectomy is done without the operator knowing of the condition, a great detriment to the patient may result.

Illustrating this point is a second case. A 55-year-old woman was first seen in 1951, about four months after a large tumor of the ovary had been removed. She had never stopped menstruating, and after operation bleeding had been almost continuous. A pelvic examination revealed the upper half of the vagina full of carcinomatous tissue. Examination of a specimen of this tissue showed it to be adenocarcinoma. Radium was inserted, and six weeks later total hysterectomy was done. The large tumor of the ovary removed at the first operation was also adenocarcinoma. The microscopic appearance of the two tumors was almost identical. At the time of hysterectomy, there was no evidence of residual tumor in the abdomen. The patient when last seen in July, 1957, was well and without evidence of residual carcinoma six years after operation. This patient was evidently operated on for pelvic tumor without preliminary dilatation and curettage, so the primary cause of the bleeding was missed. She could have been saved at least one operation and perhaps two had a little more time been expended in preparation.

Prophylactic Ovariectomy

There has been comment in the literature about the possibility of avoiding future trouble with ovarian tumors by removing one or another of the normal ovaries when a sterilizing procedure is done. This seems to be a sensible concept, as there is no good proof that a woman needs more than one functioning ovary to supply her hormonal needs and there is no evidence to show that a single remaining ovary causes pathologic changes in that ovary. Every physician has seen women who have had as many children as they desired even though they have only one tube and ovary remaining. Siddall and Levine[1] have recently suggested that the left ovary be removed if a prophylactic ovariectomy is to be done. After studying 500 ovarian tumors, they found that 48.2 per cent occurred in the left ovary, 37.6 per cent occurred in the right ovary, and 15 per cent were bilateral. The site of origin of 3.6 per cent was unknown to them. From this finding, it would seem to be of considerable advantage to take out the left ovary if one is choosing between two normal appearing organs.

A short case report will illustrate this point. A 33-year-old negro female was operated on by me for multiple fibroid tumors of the uterus in 1950. She had been having much disability due to metrorrhagia. At the time of operation a total hysterectomy and appendectomy were done. As both ovaries appeared grossly normal,

both were preserved. Only ten months later the patient was again in the hospital. She was found to have abdominal carcinomatosis. The site of origin was apparently the left ovary. Had this ovary been removed at the time of the first operation, she might still be up and around and able to take nourishment.

Total Hysterectomy

I hope that most surgeons who do gynecologic surgery now do a total hysterectomy when a hysterectomy is indicated. Many conditions which have considerable nuisance value and others more serious, can occur in a retained cervical stump. One of these conditions which causes considerable apprehension to both patient and doctor is encountered when a little endometrial tissue is left in the top of the cervix after the fundus has been removed. This is not so alarming when cyclic bleeding occurs, but often bleeding may occur only at long intervals. This situation necessitates considerable study before one can be sure that nothing more serious is present, and then one sometimes has trouble convincing the patient that she need not worry.

The true incidence of carcinoma in a retained cervical stump has been reported by various observers as varying between .28 per cent and 2 per cent. Most observers seem to think it occurs in about 1 per cent of cases, which is about the incidence in general. Epidermoid carcinoma in a cervical stump is not as readily cured as one which occurs when a supracervical hysterectomy had not previously been done.

This fact alone is enough to endorse total hysterectomy as a procedure of choice. It takes only a little more time to accomplish and adds little to the postoperative morbidity. The only real criticism is that it slightly shortens the vagina. This is certainly not a prohibitive complaint. Illustration of carcinoma occurring in a cervical stump many years after supracervical hysterectomy is as follows: This patient was 67 years of age in 1952. She presented herself with a complaint of urinary incontinence and a protrusion from the vagina. She had a third degree cystocele and a second degree prolapse of the cervical stump. She had had a supracervical hysterectomy in 1936. There was a granular lesion on the anterior lip of the cervix. A biopsy of this lesion showed it to be epidermoid carcinoma. She was treated with radium and roentgen ray with good results. She continued to have trouble with urinary incontinence, so in January, 1957, the cervical stump was removed and a colporrhaphy and perineorrhaphy were carried out. Pathologic examination revealed no evidence of residual carcinoma in the removed cervical stump.

Sterilizing Procedures

Sterilizing procedures which do not include hysterectomy lead to more repeated operations on the female than any other cause. These second operations could be entirely avoided in most instances. One is frequently consulted by patients who have had either tubal ligation or bilateral salpingectomy done previously. These patients are now having menometrorrhagia, which generally has started three to five years after their operation. They have been given innumerable shots and pills, and have sustained much loss of time and considerable discomfort to say nothing of embarrassment at unexpected intervals from their vaginal bleeding. These conditions can occasionally be controlled by cyclic therapy, but this is an expensive and continuing proposition. Finally, in their desperation they almost demand that surgical intervention be done. The following case illustrates this condition: A 36-year-old white woman, who had been married for 15 years, had had two normal pregnancies. In an operation seven years ago, one tube had been removed and the other tube interrupted. For the last five years she had been having very heavy bleeding at the time of her menstrual periods and in the last year had been having two or three episodes of bleeding a month. Hormone therapy had helped at times but had not always controlled her trouble.

Her uterus was third degree retroflexed and the fundus was fixed in the cul de sac and was about twice normal size without palpable tumor. Pressure on the fixed fundus through the posterior fornix caused considerable pain, which undoubtedly caused her dyspareunia, which she said, was quite severe at times. In view of her long continued trouble and as she said that she had to have relief from her bleeding and as she was already sterile from her previous operation, total hysterectomy was advised and accepted. Pathologic report of the tissue removed showed nothing but uterine hypertrophy and cystic endometrial hyperplasia; the removed left ovary revealed nothing unusual. She is now completely rehabilitated

and is very grateful. Her husband is also very grateful.

Why do the patients who have had bilateral tubal ligation or bilateral salpingectomy so frequently have these menstrual difficulties? The only explanation that I can offer is that of interference with the blood supply to the ovaries. The ovary receives its blood from two sources. The main supply comes from the ovarian artery, a branch of the abdominal aorta. This vessel courses inferiorly and slightly laterally on the anterior surface of the iliopsoas muscle on each side. It enters the broad ligament and courses medially, gives off branches to the ovary and tube, and anastomoses with the terminal branch of the uterine artery just below the isthmus of the tube near the cornu of the uterus on each side. Unless extreme care is taken when the tubes are interrupted and ligated, the artery will be injured or ligated.

Progressive proximal thrombosis may take place in this artery, and it will interfere with the nourishment of the ovaries. When bilateral salpingectomy is done, this embarrassment is even more likely to take place. Microscopic examination of the endometrium in a majority of these patients will reveal one of the phases of endometrial hyperplasia to be present. These patients are evidently not ovulating, and the only reasonable explanation of why they are not is that the nourishment of the ovary has been decreased to the point where the organ cannot function normally. There has certainly been no interference with the function of the pituitary gland to produce its follicle-stimulating hormones. A great majority of the ovaries in these patients contain no corpora lutea, another sign that the follicles are not proceeding to maturity and ovulation occurring. If a sterilizing operation is to be done, the uterus no longer has any function and should be removed to prevent future disability—physical, mental, and economic. There have been comments that if the menstrual function is removed psychological changes may take place. If one asks the average, mature woman who has her family how she feels about menstruation, she will almost invariably assure you that she would be very happy never to have to menstruate again.

There is a possible exception to the idea that sterilization by tubal ligation interferes with the blood supply to the ovary. One almost never sees a patient with this difficulty when the tubal interruption was done in the immediate postpartum period. One supposes that this is because the branch of the uterine artery which anastomoses with the ovarian artery is much larger and therefore more easily seen at that time and also is probably relatively farther away from the isthmus of the tube than when the uterus is of normal size. In this case, injury to the vessel is not as likely to occur.

Prophylactic Hysterectomy

In the days before antibiotics and the now commonplace availability of blood, it was probably mandatory to remove only the tubes when dealing with a pelvis involved in extensive infection. To have done more, i.e., hysterectomy may have resulted in death of the patient from sepsis. Since the addition of these and other adjuncts, almost all patients can be prepared sufficiently before operation to make a more aggressive attack safe and thereby spare the patient from future operations. However, we still see these patients all too frequently. One of the objections to hysterectomy, if sterilization is the only point to the operation or if salpingectomy is mandatory for any reason, is the possible effect on the sex life of the patient, especially the relatively young patient. My impression is that the sexual satisfaction which these patients experience is improved if changed at all. Also it is my impression that if young women have their sex life established and then for some unfortunate reason must have hysterectomy and bilateral salpingo-oophorectomy done, the operations still will not keep them from complete sexual satisfaction.

The case of an 18-year-old girl illustrates this point. She had to have both ovaries removed because of malignant granulosa cell tumor of both ovaries. The larger, arising from the left ovary, was a huge tumor filling the abdomen and weighed more than 3,600 grams. Total hysterectomy was also done. She was married; and now, three years after operation, she says that she has no complaints as far as sexual satisfaction is concerned.

A recent report of Jacob, Bailey and Willes[2] is of interest in this connection. They followed 46 young women who were under 30 years of age and who had undergone hysterectomy. The follow-up varies from one to two and one-half years after the surgical procedure. These pa-

tients were asked, among other things: (1) Has the operation affected your sex life? (2) Are you concerned that you will have no future menstrual periods? Of the 46, 28 reported no change in their sex life. Seven of these patients had had both adnexa removed. Thirteen experienced more sexual satisfaction after the operation. These thirteen had had severe dyspareunia before surgery. Five reported slightly less satisfaction. Not one patient of the 46 expressed concern over the loss of menstrual function per se. There is plenty of precedent for the prophylactic removal of a useless, but potentially dangerous, part of the human anatomy. The appendix is the time-honored example. It is removed more or less as an afterthought in thousands of patients every day. Acute appendicitis or even a carcinoid of the appendix is more easily cured than squamous cell carcinoma of the cervix uteri, adenocarcinoma of the fundus uteri and especially carcinoma of the ovary. So why preserve the uterus when the abdomen is open and its future usefulness has been destroyed?

Summary

Some of the conditions which frequently lead to repeated pelvic surgery on the female pelvic viscera have been mentioned. A suggestion has been made for more complete examination and diagnostic measures when gynecological procedures are to be done transabdominally. These measures may help prevent errors of omission as well as of commission. It is suggested that piecemeal removal of the female pelvic viscera is unjustified either medically, psychologically, or economically. Seemingly radical surgery may actually be conservative when viewed with an eye for the future.

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Prayer of the Woods

I am the heat of your hearth on the cold winter nights,
The friendly shade screening you from the summer sun,
And my fruits are refreshing draughts quenching your thirst as you journey on.
I am the beam that holds your house, the board of your table,
The bed on which you lie,
And the timber that builds your boat.
I am the handle of your hoe, the door of your homestead,
The woods of your cradle, and the shell of your coffin.
I am the bread of kindness and the flower of beauty.
Ye who pass by, listen to my prayer: harm me not.

—from ancient Portuguese verse

THE SIGNIFICANCE OF BLADDER DYSFUNCTION*

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ABNORMALITIES of urination do not necessarily reflect bladder pathology but may be indicative of systemic disease. It is for this reason that a history of the patient's urinary habits may disclose pathology indirectly associated with the urinary tract. An outstanding example of this is the polyuria of diabetes mellitus.

Classification

The causes of disturbances in urination from bladder pathology may be divided into two major groups: 1) myogenic, or local muscular dysfunction due to obstruction and 2) neurogenic, or disturbances of the nerves innervating the bladder. At first glance it would seem that these two conditions would not present a diagnostic problem, but this is not always true and often they present similar findings. Differentiation is possible only by a detailed study of the patient's general condition as well as his urologic status.

Detrusor Decompensation

The tired and hesitant urinary stream of the aged that virtually falls off the urethral meatus is diagnostic of diminished intravesical pressure. This means that the bladder muscle is exhausted and can not muster the force necessary to initiate urination instantly and even when started, urination lacks force due to detrusor decompensation. Detrusor, like cardiac decompensation follows a similar pattern. Both are preceded by a variable period of hypertrophy which reaches its limits and is followed by failure. If bladder decompensation is complete, urination is impossible, but as compared to the heart, failure is not nearly so rapidly tragic. However, unattended, it leads to renal failure.

It is important to recognize the changes of urination associated with detrusor hypertrophy and avoid the much less reversible situation of detrusor decompensation. During bladder hypertrophy emptying or voiding is frequent and scant. In other words, there is urinary frequency without noticeable straining or alteration of the urinary stream. This process gradually worsens, but owing to its incipiency the patient is unaware of its progression.

Urethral Obstruction

The cause of the above mentioned symptoms is obstruction of the urinary tract beyond the bladder; namely, in the urethra. These obstructions may be close to the vesical neck as in hypertrophy of the prostate or may be due to a stricture in any portion of the urethra, remembering that strictures in the female are not uncommon. Strictures may be either acquired (inflammatory, traumatic or prostatic hypertrophy) or congenital (urethral meatal stenosis, muscular hypertrophy or fibrous stenosis of the vesical neck).

There is a fundamental difference between the urinary stream of a patient with a urethral stricture and that associated with an enlarged prostate. This difference is due to the location of the obstruction; ie., the further from the urethral meatus the less the force of the urinary stream. It is identical to kinking a garden hose a few feet from its opening as compared to partially obstructing its outlet. We know that incompletely obstructing the outlet of the hose results in a smaller but more forceful stream. On the other hand, kinking the hose a few feet from its outlet destroys the stream and offers the advantages of a soaker. The same applies to the urinary stream. A stricture in the anterior urethra will result in a proportionally small, but powerful stream, whereas an obstruction at the vesical neck causes the urine to flow with little or no force and it virtually falls from the urethral meatus.

Neurologic Lesions

Neurologic lesions affecting the detrusor result in the prostatic type urinary stream. The bladder is unable to exert sufficient force to expel the urine except in a very slow stream, frequently and in small amounts. Furthermore, in lesions of the postero-lateral columns of the spinal cord there is associated sensory disturbance and the patient is not aware of his incompletely emptied bladder. The bladder continues to over distend until its limit is reached and urine leakage occurs either intermittently or continuously. Bed wetting usually precedes

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diurnal incontinence due to relaxation during sleep.

Congenital Obstructions

These neurogenic disturbances of vesical atonia, over distension, leakage and lack of urinary force are not limited to the traumatic and luetic group. In fact, they are prominent in the not infrequent cord lesions associated with diabetes mellitus, pernicious anemia, multiple sclerosis, arteriosclerosis or any condition in which the posterolateral columns of the spinal cord are disturbed.

Another type of voiding, seen particularly in infants and children, is that which is associated with straining during urination with or without pain. Intermittently the infant or child becomes flushed, the temporal veins distend and there is passed but a small increment of urine. These symptoms are due to congenital obstructions of the vesical neck and whether they are muscular hypertrophy, fibrosis or urethral valves is of little moment. It is mandatory, if the urinary tract is to be saved from total destruction, that an immediate urologic survey is launched and corrective surgery executed. The diagnosis of bladder neck obstruction is easily established by catheterizing the child immediately post-voiding. If more than 10 cc. residual urine is found, the child is in need of a detailed study.

Incontinence

Enuresis or bed wetting is not an unusual complaint in children, but one must take time to obtain a sufficiently careful history so that the diagnosis of enuresis is firmly established. It must be unequivocally ascertained that the urine leakage occurs only at night and that the child is always dry during the day. If incontinence of urine occurs both day and night, we must know of its pattern; whether or not it is consistent, intermittent or continuous. An ectopic ureter emptying below the vesical sphincter may cause a continuous loss of urine. On the other hand, if the kidney, associated with the ectopic ureteral orifice, is sufficiently hydronephrotic it may leak only when the contiguous flank musculature compresses the kidney. Thus, the child may be wet intermittently during the day and continuously at night when the kidney and ureter are overfilled. One such child came to our attention and after careful questioning the mother changed her story from one of pure enuresis and admitted irregular soiling of the child's clothes during the day during active play, in addition to continuous urine leakage during long periods of inactivity or during the night. Pyelography demonstrated a hydronephrotic upper segment of a duplicated kidney. The ureteral orifice emptied just below the normal urethra in the vaginal septum. Heminephrectomy and ureterectomy solved the problem.

Intermittent Obstructions

A severe bout of fever may be terminated by the sudden appearance of pronounced polyuria which may last for an hour or two or a matter of a day. Pyuria is not necessarily present. This peculiar picture of bladder activity is characteristic of intermittently obstructed hydropephrosis. During periods of stagnation the infection runs rampant, then subsides suddenly when spontaneous drainage of the hydronephrotic kidney occurs. Those patients may herald their period of polyuria with gastro-intestinal symptoms which may be of a few hours or a few days duration. This is occasioned by the greatly hydronephrotic kidney disturbing the splanchnic nerves. It is well to remember that gastro-intestinal complaints in the face of a normal gastro-intestinal series suggest the need of a urinary tract survey.

Occasionally a patient notes that the urinary stream is suddenly interrupted and purely by chance he finds that by changing his position he can again initiate urination. This is due to a ball valve bladder neck obstruction, usually a bladder stone or a pedunculated tumor.

Other Conditions

Hunner ulcer or interstitial cystitis cause continuous severe urinary frequently with point tenderness just above the pubis on bladder filling. The area of point tenderness and lack of pyuria distinguishes this condition from the intolerable frequency of bladder tuberculosis.

Urinary stress incontinence is seen most often in women and is due to inadequate support of the vesical neck. The bladder capacity is normal and leakage occurs only during a sudden increase of intra-abdominal pressure, as in coughing, sneezing, laughing, or lifting. This symptom must be carefully differentiated from the pseudo-incontinence of a hypertonic bladder associated with irritative lesions of the vesical neck or certain neurogenic disturbances. True stress incontinence is surgically easily correctable whereas pseudo-incontinence is strictly a non-surgical problem.

The deep pelvic pain of the filling bladder

which is interrupted by a brief comfort as the bladder is almost full only to recur as the bladder empties is characteristic of the urinary picture associated with active diverticulitis of the colon which produces vesical adhesions and detrusor inflammation. These unfortunates experience comfort only during the brief interval when the bladder is almost filled and there is a minimum of bladder wall excursion. In severe and persistent cases surgery must be employed and often is most difficult.

Summary

Several of the more characteristic types of bladder dysfunction are discussed with reference to their cause and voiding pattern. The importance of a thorough investigation of all patients with bladder symptoms is stressed since vesical symptoms may be a manifestation of distant disease rather than local pathology.

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THE TRAUMATIC SPLEEN*

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With the increase in automobile accidents and the multiple injuries usually produced, the abdomen, along with the head, chest, and extremities is by no means overlooked. Of the intra-abdominal organs, the spleen is one of the most frequently injured.

A recent survey[1] of ruptured spleens on the surgical service of the Los Angeles County General Hospital over a 10-year-period revealed some interesting findings. One hundred and one patients were splenectomized as an emergency surgical procedure following accidents in which there was trauma to the abdomen and chest. The over-all mortality was 16.8 per cent, with the highest rate occurring in those patients with multiple injuries. Mortality rates vary from 5.5 per cent to 46 per cent in reported series,[2] averaging 20-25 per cent. There is a 7 per cent mortality rate in the present series taken from Good Samaritan Hospital in the last 5 years.

Associated Injuries

Rupture of the spleen is a peritoneal lesion, and generally an isolated one, not associated with rupture of other abdominal viscera. The most frequently associated abdominal injury is rupture of the left kidney but only occasionally is nephrectomy necessary. The left kidney is injured in about 27 per cent of the cases.

Trauma causing rupture of the spleen is usually directed against the left chest, flank or abdomen. Rib fractures occur in about 60 per cent of the cases. The left 8th and 9th ribs, called the splenic ribs, are the most frequently affected. Costal trauma pain may lead to error in diagnosis if nerve infiltration is carried out after fractures. The patient feels better and leaves the Emergency Room only to return some 6-8 hours later in vascular collapse from massive intra-peritoneal hemorrhage. Without nerve infiltration these cases would have symptoms suggestive of splenic trauma. It is interesting to note an almost complete absence of case reports of rupture of the spleen in baseball, basketball or other sports.

Lacerations of the spleen vary according to gross findings. They may be classified as follows: Single lacerations, 15 per cent; Multiple or stellate lacerations, 25 per cent; Bisected spleen, 10 per cent; Completely macerated spleen, 10 per cent; Lower pole and pedicle, 20 per cent; Subcapsular hematoma, 20 per cent.[1] Of more importance from a clinical viewpoint, they are further classified on the basis of immediate hemorrhage and delayed hemorrhage. Approximately three fourths of these patients are operated on within 24 hours following trauma and are usually classified as having immediate hemorrhage. The remainder require surgery 48 hours to 35 days following trauma and are classified as having delayed hemorrhage.

Immediate Hemorrhage

Immediate hemorrhage occurs in all cases in which there is laceration of the spleen and the splenic capsule. In those cases in which hemorrhage is intrasplenic with an intact capsule, the intra-abdominal hemorrhage is delayed. In some cases with laceration thru the spleen and capsule, hemorrhage may be delayed by some form of tamponade. This can occur in three ways: A simple laceration with formation of a blood clot and temporary hemostasis; the plugging of lacerations by the omentum; or walling off of hemorrhage on the diaphragmatic surface of the spleen by the stomach, omentum and colon. Straining, coughing, vomiting or over-eating may furnish the mechanism to re-start a walled-off hemorrhage.

The clinical picture of an immediate traumatic rupture of the spleen is quite well known and conforms to the definite pattern of trauma to the left chest or abdomen by a direct blow or fall, followed by a latent period (usually 6 to 10 hours) which may extend to 24 hours in which the patient is relatively symptom-free or has vague, indefinite abdominal or chest findings, only to lapse into sudden collapse from massive intra-abdominal hemorrhage. These cases are readily diagnosed.

On the other hand, the patient first seen with multiple injuries often presents a very difficult diagnostic problem. The difficulty is

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two-fold. First, multiple lacerations and fractures produce shock and the possibility of intra-abdominal injury is overlooked. Second, transfusion masks the clinical evidence of early intra-abdominal bleeding. It is only by careful, repeated examinations in the first 24-48 hours that one can make the early diagnosis of rupture of the spleen. Delayed rupture may occur as long as five weeks following initial trauma. During this interval the patient may be asymptomatic or complain of vague left abdominal or chest soreness, bloating, or vague gastro-intestinal distress, only to experience sudden severe abdominal pain with signs of intra-abdominal blood loss as secondary hemorrhage occurs. Some patients with subcapsular hematoma have persistent left upper quadrant pain and gastro-intestinal symptoms of sufficient magnitude to bring them to a physician before secondary rupture can occur. In these cases, left upper abdominal tenderness, rigidity, and mass with evidence of anemia are diagnostic.

The signs of intra-peritoneal bleeding from a ruptured spleen always include tenderness and rigidity in the left upper quadrant of the abdomen. Pain in the left shoulder (Kehr's sign) and pain in the left chest on deep breathing may be present. The most constant diagnostic triad includes abdominal pain, tenderness and rigidity in the left upper quadrant and left shoulder pain.

Delayed Hemorrhage

In delayed hemorrhage or when symptoms are atypical, roentgenography may contribute considerably to the diagnosis. A recent series from Massachusetts General Hospital[3] reported forty-three patients with ruptured spleens. Thirty-three had x-rays. Twenty-five cases showed complete obliteration of the splenic shadow and six showed partial obliteration. Other important findings include:

(1) Irregularity or localized indentation of the greater curvature of the stomach (50%).

(2) Fracture of one or more ribs on the left side (27%).

(3) Inferior displacement of the left kidney.

(4) Abdominal fluid.

(5) Left pleural fluid.

(6) Widening of the left paravertebral shadow in the thoracic region.

(7) Limitation of motion of the left diaphragm.

The most reliable *negative* finding is a small well outlined spleen. If symptoms persist, repeated examination may be necessary.

Blood counts may be of considerable value even though in the majority of cases the presence of hemorrhage is obvious. Trauma involving the intestine or kidney is usually not associated with the prompt leukocytosis seen in splenic or liver trauma. The increase in leukocytes is inversely proportional to the hemoglobin level in cases seen late. In a recent study by Berman[4] concerning thirty-eight consecutive cases of traumatic rupture of the spleen, 79 per cent had a leukocyte count above 15,000 per cubic millimeter; 42 per cent above 20,000, and 15 per cent above 25,000. When abdominal symptoms are corroborative, a leukocyte count of over 15,000 suggests rupture of the liver or spleen.[4] In our series (Fig. 1), 78 per cent had a leukocytosis over 18,700. The leukocyte count varied from 11,000 to 34,200.

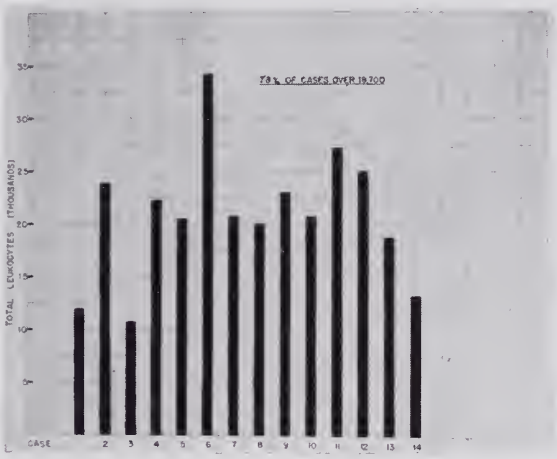


Figure 1

Diagnostic abdominal paracentesis may be of considerable value in early cases. Those who adhere to this diagnostic measure recommend a tap in each of the four quadrants before a negative opinion can be given.[1]

Permanent Disability

Of considerable interest is the question of permanent disability following splenectomy. In 1946 Dameshek[6] reviewed the literature and summed it up when he stated that the spleen seemed to be a rather useless organ because its removal in the normal human being was unattended by noticeable clinical effects.

The Mayo Clinic[5] published a collective review of the effect of splenic function and disease on the female physiology. They concluded that certain splenic diseases and the disordered

physiology resulting therefrom, on occasion, can become of tremendous importance to the obstetrician. The records of 182 pregnancies after splenectomy, *for splenic disease,* demonstrated a fertility rate of 65 per cent after splenectomy, a fetal survival of 75 per cent, and a maternal mortality rate of 3 per cent in the spleenless woman. It was concluded that the maternal and fetal mortality risk of patients whose spleens were removed for splenic anemia and Banti's disease distinctly exceeded the normal. Those whose spleens were removed for thrombocytopenic purpura or congenital hemolytic icterus showed no greater pregnancy hazard than did the normal woman.

More recently King and Schumaker[7] discussed the susceptibility to infection after splenectomy in infancy. Of 100 splenectomies performed at Indiana Medical Center, five were in infants less than 6 months of age. Four of these five developed either meningitis or an overwhelming meningococcemia in from six weeks to three years after operation, a mortality occurring in one of these cases. A fifth child died soon after discharge, of a short, rapidly fatal, febrile illness.

There is considerable literature concerning the relationship of the spleen to the resistance to infection. The evidence is grouped into four main categories.[7]

(1) Enlargement, proliferation of cells of macrophage system and hyperplasia of lymphatic tissue in infections.

(2) Latent infections are activated following splenectomy in experimental animals.

(3) Suggestive evidence that in certain animal species splenectomy depresses the natural resistance to acute and chronic infection.

(4) Since the spleen is the largest single reservoir of lymphocytes and since lymphocytes have been demonstrated to play a major role in antibody formation, the spleen would appear to play a major role in this important defense mechanism.

Rowley[8] has studied circulating antibody titre in splenectomized patients and found a failure in the rise of antibody titre in a small group.

A recent Swedish[9] study concerns 18 adult patients who were splenectomized for traumatic injuries and followed up to 26 years. Each of these patients was followed with blood, bone marrow and iron tolerance studies. It was the conclusion of these authors that splenectomy had no effect on the general health of the individual.

Gofstein and Cellis[10] reviewed 200 cases from Children's Memorial Center in Boston between 1930 and 1950. Most of these children were less than 10 years of age. The authors' conclusion was that splenectomy performed in infants less than 1 year of age is infrequently followed by severe infections. There does, however, appear to be a correlation between splenectomy and sepsis apparently independent of age. Incidence although not great was 5 per cent in their series. The matter of proneness to sepsis awaits further study.

In summary, in spite of the known relationship of the spleen to antibody formation and its demonstrated role in resistance to infection in certain animal species, no significant hazard of infection appears to follow splenectomy in human adults or children. Recent experience suggests, however, that when splenectomy is performed during the first few months of life there may follow, at least for a time, an increased susceptibility to infection.[7]

Summary of Series Studied

Fourteen cases of traumatic rupture of the spleen were seen at Good Samaritan Hospital in the last five years. The prominent symptoms and findings are outlined in Fig. 2. The patients' ages varied from 6 to 60 years. The type of trauma was equally divided between fall and automobile or cycle accidents. Interval between trauma and diagnosis of rupture varied; eight cases within 24 hours, and six cases from

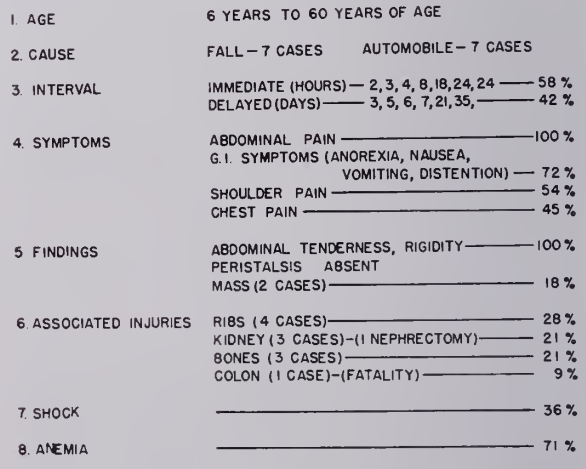


Figure 2

3 to 35 days. Thus in the majority of cases, rupture occurred within 24 hours and of these, the 63 per cent occurred after eight hours. Delayed rupture occurred up to 35 days. The symptoms in our cases were similar to other series. Abdominal pain was always present. Gastro-intestinal symptoms such as anorexia, nausea, vomiting and distention were present in 72 per cent of the cases. Shoulder and chest pain were present in about one half of the cases. Abdominal tenderness and rigidity were always present and peristalsis was usually diminished. Abdominal masses were palpated in only ten of the cases.

The most frequent associated injury appeared to be rib fractures, these occurring in almost one third of the cases. Kidney injury as evidenced by hematuria was found in one fifth of the cases but in only one of these was nephrectomy necessary. Fractures other than ribs were found in three cases. The only case in which an associated intraperitoneal abdominal visceral injury occurred, involved a ruptured colon and accounted for the one fatality. Anemia was present more frequently than was shock, occurring almost twice as often.

Summary

1. Traumatic rupture of the spleen most frequently follows the trauma of falls or automobile accidents.

2. Rupture occurs within twenty-four hours in the majority of cases but may be delayed up to thirty-five days.

3. The symptoms and findings are reviewed.

4. Elevated leukocytosis occurs early in liver or splenic trauma and is often of diagnostic significance.

5. Disability following splenectomy is doubtful in the healthy adult, but there may be an increased susceptibility to infection, at least for a time, in the very young.

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There's no joy even in beautiful Wisdom,
Unless one have holy Health.

—Simonides of Ceos

Acute Cecitis

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THIS is a relatively rare disease entity, according to the surgical literature, as less than 50 cases have been reported. It is not mentioned in most text books of surgery and when reference to it does appear it is given very little space. It is my belief that it is important and that it should receive more consideration. Tagart[6] in 1953 was able to collect only 21 cases from the medical literature from the previous 25 years and then added 3 cases of his own. Phlegmonous inflammation of the cecum secondary to appendicitis or diverticulitis will be excluded from this discussion except as a case of differential diagnosis.

Definition

Phlegmonous cecitis is a suppurative inflammation of the cecal wall beginning as a cellulitis of the submucosa and terminating in a circumscribed or a diffuse inflammation.

Etiology

It is reasonable to assume that the condition is caused by bacterial infection. Such studies to prove this point are scant in the literature but the predominant organisms have been found to be streptococci and staphylococci alone or in combination. B. coli and pneumococci are also mentioned as causative agents. Abrasions of the mocusa are usually blamed for the point of entry of the organisms although hematogenous mode of infection is mentioned in the literature.

Pathology

The best description available is from Spivak and Busch[5] and the following is a quote from their article. "Phlegmonous cecitis may be divided into two types; the circumscribed phlegmon and the diffuse phlegmon. The circumscribed phlegmon of the cecum is characterized by an irregularly oval or circular area of edema and redness sharply differentiated from the surrounding normal tissue. The area is frequently covered by thin grayish yellow fibrin and feels doughy. Occasionally there is a central softening in the mass due to abscess formation or to ulceration of the mucosa. The peritoneal cavity is relatively free of reactive fluid in this type.

The diffuse phlegmon is characterized by a marked edema of the entire cecum and in contra-distinction to the localized form its borders merge imperceptibly into the normal ascending colon. The edema is more pronounced and the involved area is angry purple red. The fibrinous exudate is thicker, shaggier and more grayish in appearance. In this type there are numerous punctate hemorrhages throughout the involved area. On palpation the diffuse phlegmon is of a firm rubbery consistency. In most of these cases there is a reactive peritonitis as evidenced by turbid fluid and wide spread deposit of fibrin.

The microscopic picture is essentially the same in both types. This consists of a profuse exudation of a collagen-rich fluid in the submucosa and to a lesser extent in the subserosa. There is an infiltration of leucocytes in both these areas and in the circumscribed type this infiltration frequently terminates in focal abscesses which may coalesce in the submucosa to form larger abscesses. The muscularis and the mucosa are involved in the process but to a much lesser degree. Occasionally an ulcer in the mucosa may form due to the presence of abscesses in the submucosa which break through into the lumen of the gut.

The microscopic process always extends for a considerable distance further than is evidenced by the gross appearance."

Clinical Features

The symptoms, physicals signs and laboratory findings closely simulate acute appendicitis or appendiceal abscess. Most of the cases are found to have a short history varying from a few hours to a few days. It has been mentioned that a palpable mass in the right lower quadrant of the abdomen within forty-eight hours after the onset of the symptoms should lead one to suspect this disease but this has not been found to be true in cases reported by Emmett.[2] It seems to me that the pre-operative diagnosis of acute cecitis is relatively unimportant and that the emphasis should be placed on the differential diagnosis at the operating table. Occasionally one is confronted with a secondary acute cecitis which appears to be out of proportion to the degree of primary inflammation in the appendix. A solitary diver-

ticulitis of the cecum may at times present a picture that is indistinguishable from the localized form of acute cecitis as will be demonstrated in one of our cases.

Treatment

Operation is indicated because of the difficulty of making a differential diagnosis. A great many cases have been subjected to ileocecal resection. This condition has a tendency to resolve without sequelae but at times it may progress to perforation with generalized peritonitis. First in importance is the awareness that such an entity exists. Having such an awareness, the surgeon may recognize the condition at the operating table. About one fourth of the cases reported in the literature have been subjected to radical ileocolic resections. The consensus of opinion is that in uncomplicated cases of primary cecitis the procedure of choice is not to disturb the cecum other than, perhaps, to take a biopsy specimen, but even this seems to us to be hazardous due to the marked edema of the tissues. If perforation appears to be imminent Tagart[6] suggests the following: "The whole inflamed area may be excised and the cecum closed in two layers if the inflammatory area is limited in its size. The inflamed area may be oversewn or invaginated if the surrounding bowel wall is not too edematous. If perforation has occurred and there is not too much edema the perforation may be successfully closed and the area covered with an omental graft." Some authors have suggested cecostomy in this type of case. Perforations with more extensive defects may require exteriorization procedures or a resection.

Prognosis

The mortality for this disease is usually reported to be about 10% but some of these cases were before the use of antibiotics. Other reports have given a much higher mortality but these were cases that were subjected to extensive resections.

Case Reports

CASE # 1

Mrs. R. J., age 45. Admitted to St. Joseph Hospital, Lexington, Ky., September 11, 1954. This patient gave a history of having diarrhea one week previously which subsided in two days. Forty-eight hours prior to admission she developed generalized abdominal pain which persisted for one day and then became localized in the right lower quadrant where it remained. There were nausea and anorexia but no vomiting. There was no bowel movement the day of admission.

EXAMINATION: Temperature 99.2, Pulse 100. Resp. 20. Blood pressure 140/80. Heart and lungs: Not remarkable.

Abdomen: Peristalsis present and normal. There was three plus tenderness in the right lower quadrant with marked muscle spasm. No rebound tenderness. The remainder of the abdomen was soft and non-tender.

Pelvic: The support was adequate. The cervix was clean. The corpus was average size and anterior. There was two plus tenderness in the right adnexal region but no mass.

Rectal: No masses felt.

LABORATORY WORK: RBC 4,950,000; Hemoglobin 14.8 gms. WBC 12,100. Polys. 82. Lymphs 18. Urine: Clear, acid, specific gravity 1.015. Albumin: Negative. Sugar: Negative. Microscopic: Occasional WBC, 3 to 4 RBC.

This patient was taken to the operating room a few hours after admission and the peritoneal cavity entered through a short right rectus muscle splitting incision. Cloudy fluid was present and the cecum was found to be markedly inflamed and very edematous. There was a fibrinous exudate over the surface. No tumor masses could be felt in the walls of the cecum. The serosa split along a tenia from the trauma of examination. The terminal ileum appeared normal. The appendix showed only slight edema and as the base was not involved to any great extent it was removed. Pathology: Essentially normal appendix.

COURSE IN HOSPITAL: This patient was put on a combination of penicillin and streptomycin and the post operative course was uneventful. The highest temperature was 100.2. She was discharged from the hospital on 9-18-54.

This patient was admitted again to the same hospital December 1, 1954 with a typical history and findings of acute cholecystitis. At operation the gall bladder was found to be greatly distended and acutely inflamed and contained several stones. A cholecystectomy was done and the cecum was then delivered into the wound and found to be completely normal. She was discharged from the hospital on 12-9-54.

CASE # 2

Mrs. D. M. Age 40. Admitted to Good Samaritan Hospital, Lexington, Ky., June 25, 1957. She complained of epigastric pain which

had started 36 hours previously and was followed by nausea and anorexia. The pain later became colicky in nature in the lower abdomen and localized in the right lower quadrant. There had been no bowel movements since onset.

Past history was negative, except for some epigastric distress occasionally which was unrelated to food and which had been diagnosed as nervous indigestion.

EXAMINATION: A well developed and well nourished white female. Temperature 99.2. Pulse 100. Blood pressure 108/68.

Abdomen: Peristalsis was present but hypoactive. There was three plus tenderness in the right lower quadrant with muscle spasm. At the point of maximum tenderness a mass about 8 cms. in diameter could be felt located just slightly above McBurney's point. The remainder of the abdomen was soft and non-tender. Pelvic: Mucus membrane: Normal. Support: Adequate. Cervix: Clean, except for a few Nabothian cysts. The corpus was anterior and average size. The adnexa was non-tender and revealed no masses.

Rectal: No masses or tenderness.

LABORATORY: RBC: 6,100,000. Hemoglobin 18.1 gms. WBC 15,200, Polys. 77, Lymphs. 16, Mono. 4, Baso. 1, Eosin. 2. Urine: Yellow, hazy, acid, specific gravity: QNS. Acetone: 2 plus. Microscopic: 0 to 4 WBC, and occasional RBC per high power field.

A diagnosis of acute appendicitis was made and the patient was taken to the operating room. A transverse muscle splitting incision was made in the right lower quadrant and the appendix was found to be normal. There was a small amount of cloudy fluid present. The cecum was found to contain a mass the size of an orange. It appeared to be inflammatory as there was marked edema superficially as well as thickening of the layers of the bowel. The process seemed to be diffuse, involving the entire cecum and extending upward. The serosa was red and there was some fibrinous exudate over it. The mesenteric nodes were slightly enlarged. The base of the appendix was not involved and so an appendectomy was done. This process was assumed to be acute cecitis but since neoplasm could not be definitely ruled out it was decided that the best course would be to close the abdomen and to re-explore at a later date after there had been sufficient time for the process to subside and at a time when the bowel had been prepared. Pathology: The appendix was essentially normal.

COURSE IN HOSPITAL: The course in the hospital was uneventful and the highest temperature reading was 100.4. She was placed on chloromycetin and a low residue diet and discharged from the hospital on the fifth post operative day.

This patient was re-admitted to the hospital on July 26, 1957 after the bowel had been prepared with Epsom salts, Sulfathalidine, and a low residue diet. The urine was negative. The chest x-ray was negative. The WBC count was 8,700, Polys. 68, Lymphs. 32, Hemoglobin 14 gms. On July 27, 1957 this patient was operated upon. The peritoneal cavity was entered through a very short right rectus incision. The cecum was delivered into the wound without difficulty and it was found that the inflammatory reaction had completely subsided and the bowel appeared normal in every respect. There was no evidence of tumor. The abdomen was then closed in layers with no further operative procedure. She was discharged from the hospital on 7-30-57 and made an uneventful recovery.

CASE # 3

D.E.B. Age 34. Admitted to Good Samaritan Hospital, Lexington, Ky., on March 15, 1957 at 11 p.m., complaining of pain in the abdomen. Onset had been 12 hours previously with right lower quadrant pain which later radiated to the epigastric region. There was anorexia but no nausea or vomiting. The pain was colicky in nature and there had been no bowel movement that day. There were no urinary symptoms. Past history: General health good except for asthma.

EXAMINATION: Temperature 98.6, Pulse 100, Respiration 20. Blood pressure 134/82.

Heart: No murmurs heard.

Lungs: There was slight wheezing in the chest characteristic of bronchial asthma.

Abdomen: Peristalsis was hypoactive. There was three plus tenderness in the right lower quadrant with muscle spasm. A tender mass 3 by 4 cms. was felt in the right lower quadrant and this could be moved about to some extent. The remainder of the abdomen was soft and non-tender.

Rectal: No masses or tenderness.

LABORATORY: Hemoglobin 17.8 gms. Microhematrocrit 47mm. WBC 14,400, Polys. 56, Lymphs. 43, Baso. 1. Urine: Yellow, clear, acid, specific gravity 1.003. Albumin negative. Sugar negative. Microscopic negative.

This patient was taken to the operating room with a diagnosis of acute appendicitis. A short transverse muscle splitting incision of the right lower quadrant was made and a mass was found in the cecum at the base of the appendix. The mass was about 3 cms. in diameter and was very firm. It was red and inflamed with slight edema about it which extended onto the base of the appendix. The terminal ileum appeared normal and there were some enlarged nodes in the mesentery. This was thought to be a tumor of the cecum or possibly the localized form of acute cecitis so the abdomen was closed and no further operative procedure done.

COURSE IN HOSPITAL: The bowel was prepared for surgery with antibiotics and low residue diet and the patient was re-operated upon on 3-20-57. A short right rectus incision was made at this time and the tumor seen five days previously had disappeared except for a small nodule 7 to 8 mm. in diameter located within 1 cm. of the base of the appendix. This nodule was dissected free lrom the surrounding tissue and found to be a diverticulum of the cecum. The appendix and enough of the cecum to excise the diverticulum was removed and the cecum closed over a clamp with a Kerr-Parker stitch. The abdomen was closed in layers without drainage. The recovery was uneventful and the patient was discharged from the hospital on 3-28-57. Pathology: Acute diverticulitis of the cecum near the base of the appendix and an essentially normal appendix.

Summary

Acute primary cecitis is apparently an uncommon disease but one which assumes importance when we are confronted with making a diagnosis of it at the operating table. The symptoms and signs are indistinguishable from those of appendicitis. In reported cases treatment has varied from doing nothing to radical resection. Post-operative barium enemas have been reported to show deformities of the cecum persisting for four to six weeks and occasionally longer even though the patient may be without symptoms.[2] If there is a question of an error in diagnosis then it is logical to reexplore the abdomen in three to four weeks, with the bowel prepared for definitive surgery should it be necessary.

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Experiences should teach us to be most on guard to protect our liberty when government's purposes are beneficent.

—Louis D. Brandeis

CARE OF THE TRACHEOTOMIZED PATIENT*

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TRACHEOTOMY has become a frequently used procedure. Injuries to the thoracic cage,[1] bulbar poliomyelitis,[2] cerebrovascular accidents, and laryngotracheal bronchitis are some of the less frequent indications for tracheotomy. Most frequently it is used in conjunction with head and neck surgery and following head trauma.

The upper respiratory passages serve to moisten, heat and filter the inhaled air. Tracheotomy interferes with the normal physiology of the respiratory system. According to Proetz,[3] 500 cubic feet of air are breathed by an adult in 24 hours. The temperature of this air is raised by the nose to 98.6 F., and the relative humidity to 95 per cent. Assuming that the room humidity is 40 per cent and the temperature is 72 degrees Fahrenheit, the nose must then add one pint of water a day to the inhaled air. Unfortunately, during the winter the humidity of a heated hospital room, when the outside temperature is 32 F. is about 8 or 12 per cent. Without the pint of water added by the nose, this dry air is destructive to the pseudostratified, columnar, ciliated epithelium of the bronchial tree. To raise the humidity in a small hospital room from 8 per cent to 40 per cent would require a pint and a half of water. If the door of the room was left open, even for a short time, the added humidity would be lost.

The mucous blanket of the lower respiratory tract is a thin, slippery, adhesive, tenacious film which is moved from the bronchioles to the trachea, through the larynx and finally swallowed. This mucous blanket acts as a conveyor system for bacteria and particulate material which enter the lower respiratory tract. Barclay and Franklin[4] found that particles were carried at a rate of 1 centimeter in four minutes in the bronchioles and 1 centimeter in one minute in the trachea. Decerebrated cats were used in their experiments.

Tracheal Encrustations

A tracheotomy tube introduced into the trachea acts as a dam to the flow of the mucous blanket, and a pile-up of secretion occurs at the inner opening of the tracheotomy tube. The mucous dries, hardens and may threaten the patient's life. Due to trauma, drying, or infections, the cilia may become damaged in other areas along the trachea or bronchi causing a "road block" to the flow of mucus from the lower bronchial tree. The mucus may then dry and harden, forming what Conley[5] has termed, "tracheal encrustations." The diagnosis of "tracheal encrustations" is made with the end of the suction catheter; however, sometimes the catheter will pass through the center of a tracheal encrustation which rarely may form a cast of the entire trachea. Respiratory distress is a late symptom of tracheal encrustations and should not occur with good nursing care. Encrustations, once they have occurred, can usually be removed by douching the trachea with 10 to 20 cubic centimeters of saline followed by suction. The inner tube may be removed from the tracheotomy tube in order to increase the diameter of the opening. If this fails, and the situation is not desperate, a bronchoscopist should be called and the encrustation removed mechanically. An occasion may arise where the airway is obstructed, in which case the entire tube should be removed and the patient asked to cough out the crust. If he fails to relieve his obstruction, it may become necessary to reach into the wound with a hemostat (or even with bare fingers) and push the crust up through the larynx into the mouth. With good nursing and medical care such a desperate situation should seldom arise.

Mucosal Edema

Drying, trauma and infection of the mucosa and submucosa produce injury resulting in edema of the mucosal and submucosal tissues. The edema reduces the lumen of the larger passages and may completely close the smaller passages. Atelectasis, and in aggravated cases, even death will result.

Routine care of the tracheotomized patient may be divided into four phases:

1. *Provision of Moisture*

A short period of drying may destroy the ciliated cells of the trachea; therefore, it is im-

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portant and difficult to provide the pint of water which normally would have been provided by the nose. A #841 DeVilbiss continuous flow nebulizer, filled with distilled water and directed into an oxygen tent, will provide the necessary humidity. If one wishes to avoid the oxygen tent, a tracheotomy shield attached to the #841 DeVilbiss nebulizer will also provide adequate moisture. In our experience, a damp cloth placed over the tracheotomy opening is of no value since the amount of water which may be absorbed from it is less than 1 cubic centimeter. Also, oxygen bubbled through water does not provide enough moisture to be of practical value.

2. *Protection Against Infection*
   a. Dusty atmosphere containing bacteria should be kept from the patient's room.
   b. Mattresses contaminated by a previous patient should be covered by plastic covers.
   c. The nurse caring for the patient should use gloves, or at least wash her hands with one of the antiseptic soaps, before suctioning the patient.



The illustration shows what we feel is a practical nursing setup for post-tracheotomy care. The tray, brought fresh and sterilized each day from Central Supply, includes the following:

   a. Three 500 c.c. Baxter bottles. One is filled with 1:10,000 Zephiran,® and the other with normal saline. The third bottle is filled with saline used to flush the trachea when necessary. This flushing is done with a 20 c.c. syringe, which is also on the tray. (A tonsil suction tip is useful in removing secretion from the hypopharynx.)
   b. Two #16 French, whistle-tip, rubber catheters (soaking in the 1:10,000 Zephiran.) Before the catheters are introduced into the trachea, the Zephiran is rinsed from the catheters. The size of the catheters must be changed in cases of infants and children.

3. *Prevention of Mechanical and Chemical Trauma*

A soft rubber #16 whistle-tip catheter is introduced slowly into the trachea, and then into the right and left stem bronchi. The catheter will go into the right bronchus when the head is tilted sharply to the left, and into the left bronchus when the head is tilted to the right. It may be necessary to introduce and remove the catheter four or five times to completely suction the bronchi. These movements should always be gentle, never "jerky" or "jabbing." Frequency of suction depends upon the patient, but for 24 hours following surgery it is usually necessary to suction the patient every half hour and sometimes more often. The frequency of suction is less on the second day and following days.

4. *Cleansing Inner Cannula*

Cleansing the inner cannula of the tracheotomy tube is important. This is best accomplished with cotton-tipped applicator sticks which have been soaked for three hours (or longer) so that they will bend around the tube curve. The use of pipe cleaners or other hard wire implements is harmful to the soft metal of the tracheotomy tube.[6] The inner cannula should be removed and cleansed every six hours. The entire tracheotomy tube should be changed after 25 hours. An extra tube is kept in a sterile jar on the post-tracheotomy tray, ready for use when the entire tube is changed.

5. *Prohibition of Use of Harmful Drugs*

According to Jackson,[5] morphine and atropine-like drugs thicken the secretions and depress the cough reflex. They should not be used in the tracheotomized patient.

Case Reports

Each of the following three cases illustrates a point in the care of the patient:

1. A 65-year-old female, on whom a tracheotomy had been done two days previously (following a cerebral accident), suddenly began to bleed from her tracheotomy wound. By the time the surgeon arrived, the patient had "drowned" in her own blood. Usually, bleeding from such a wound is venous and it can be stopped by firm pressure. Had pressure been


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applied by one nurse while the other suctioned blood from the tracheotomy tube, this case might have ended differently.

2. A tracheotomy was done on a nine-month-old infant because of laryngeal edema. Two hours later, while the nurse was suctioning the tube, it became dislodged from the trachea and the child died. This case points out that the obturator should always accompany a tracheotomized patient. If the tube should become dislodged, the inner tube is removed, the obturator put in place, and the tube put back into the tracheal opening. Of course, the obturator is immediately removed when the tube is in place.

3. A 75-year-old tracheotomized male was brought to the hospital in severe respiratory distress. He had removed the inner tube from his tracheotomy. Soon the tube became filled with hard, dry mucous and the airway was cut off. Fortunately, another tube was put into place and the patient survived. This illustrates the importance of the inner tube. It can be removed and cleansed. It serves as a safety factor which can be removed in an emergency.

Summary

The normal physiology of the lung depends upon the functioning of the mucous blanket and cilia of the trachea and bronchi, as well as upon a normal cough reflex. In the care of a tracheotomized patient, we should do everything to preserve the integrity of the ciliated mucous membrane. The most important points are: (1.) Provide moisture. (2.) Prevent trauma to the mucosa. (3.) Prevent infection. (4.) Do not use drugs which might inhibit the cough reflex, or dry and thicken the secretions. (5.) Provide adequate suction of the pulmonary tree.

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Help Us to See

O God of the infinite heavens, and the majestic sea,
God, too, of the snow crystal and the grain of sand,
We thank thee that wherever we seek thee, thou art to be found.

But sometimes when we have lost the sense of thy presence,

We have found it again beside a lake or on a mountain top or in the quiet of the forest.

We thank thee, then, today for the out-of-doors and all the beauty and the wonder of the universe that thou hast made.

Help us to use these beauty spots of thine to tune our souls to the music of eternity. Amen.

—Lowell Brestel Hazzard

Case Of Myxedema With Pericardial Effusion

Louisville General Hospital
John N. Goldsborough, M.D., Chief Resident, Department of Medicine

Clinical History

P.G. (LGH#130860), a 75-year-old white female, was admitted to the Medical Service, Louisville General Hospital on 5/22/58 with the chief complaints of being cold and sleepy.

An adequate history was difficult to obtain on admission because of the patient's pronounced lethargy. She did, however, complain of being cold and sleepy. She had also noted constipation and generalized swelling of an unknown duration, but she denied shortness of breath.

Upon review of her previous hospital record, it was discovered that she had been admitted to the Louisville General Hospital in 1954 after an automobile accident. At that time an incidental diagnosis of myxedema had been made and treatment was started with desiccated thyroid (one-half grain daily). After leaving the hospital she returned to the out-patient clinics only twice and apparently lapsed therapy.

Otherwise her past history was not particularly remarkable, except for the fact that she had never had thyroid surgery. Menarche had occurred at age 15 and menopause at age 48. She was pregnant once. There was no history of obstetrical complications. The patient had been living alone in a hotel, spending most of her time in her room.

Physical Examination

On admission the remarkable vital signs were a rectal temperature of 96.0 degrees, a pulse of 58 and a BP of 140/70. The patient was very somnolent and had a slow, hoarse speech. She was markedly edematous. The hair was coarse and unkept and the outer one third of the eyebrows was missing. The skin was cold and dry. She was noticeably deaf.

Examination of the heart revealed that the point of maximal impulse was neither visible nor palpable. The heart was enlarged to the anterior axillary line by percussion. The rate was 58, the rhythm irregular. The heart sounds were quite diminished. No murmurs were noted.

The chest was thought to be clear.

There was pitting edema of the abdominal wall and there was a moderate amount of ascites.

There was four plus pitting edema of the lower extremities.

Deep tendon reflexes were absent.

Laboratory Studies

The initial chest film (figure one) revealed



Figure 1

an enormous cardiac silhouette. In addition there was the incidental finding of the calcified, deviated trachea. We next aspirated about 50cc. of clear, yellow fluid from the pericardial sac and replaced it with 35cc. of air. One may note the fluid-air level in figure three.

An iodine uptake study revealed an uptake of 10% in 24 hours. The protein bound iodine



Figure 2



Figure 3

was 1.8 micrograms per 100 cc. (Normal in this laboratory is 4-8meg.)

The BMR was minus 37%.

The cholesterol was 174, the hemoglobin 8.7 and the white cell count 9,000 with 70% polys and 30% lymphs.

The EKG showed low voltage, bradycardia and sinus arrhythmia. There was some non-specific change of the ST segment and the T waves were flat or inverted in all leads.

The venous pressure was 220mm. of saline.

The EEG showed moderate, diffuse slowing.

Course and Treatment

On 6/6 the patient was started on one half grain of thyroid per day. A week later she was perhaps a little brighter but was essentially unchanged. She continued to have a subnormal temperature.

On 6/21 the thyroid dose was increased to one grain per day. On 7/4 it was noted that the patient was becoming increasingly irritable and difficult to manage. The dosage was unchanged, however, and within another week she had passed through this phase.

On 7/8 the venous pressure was 80mm. saline.

On 7/14 another chest film was made. In figure two one may notice the striking reduction in cardiac size. By this time her pulse rate was in the seventies and her temperature was normal.

The patient has continued to improve. She is ambulatory, has a good appetite and is quite bright and cheerful. The deafness has been ameliorated and the intolerance to cold has abated. She has lost fifteen pounds since her admission. She has had no angina or anginal like pains, and her serial electrocardiograms have shown no suggestion of myocardial ischemia. It is of interest to note that her electroencephalograms have become more nearly normal, and the deep tendon reflexes have returned.

Discussion

This case was such a classical example of myxedema that simply to have considered the diagnosis was sufficient. The first few sentences of the physical examination summate myxedema. Consequently, other diagnostic possibilities will not be considered here. Instead, a few of the interesting features of this case will be examined.

Bradycardia, feeble cardiac pulsation, cardiomegaly and low voltage on the electrocardiograph were all present. Furthermore all these findings were reversed by the administration of thyroid, thus fulfilling Zondek's original criteria.[1] The question as to the validity of the term "Myxedema Heart" was discussed by Lerman et. al. in 1933.[2] Their article casts considerable doubt that there is such a disease and indicates that the entity

represented is part of the myxedema itself.

The presence of the large amount of pericardial effusion and its contribution to the size of the cardiac silhouette was demonstrated. For some time there has existed a debate as to whether the effusion alone is responsible for the cardiomegaly or whether dilatation or hypertrophy of the heart augments the increased transverse diameter. The basis for much of the argument lies in our lack of knowledge of the cardiac pathology. Additional difficulties in this sphere are caused by associated cardiac diseases. As an illustration of this point mention might be made of another patient we have seen recently who had hypertensive heart disease in addition to myxedema with massive pericardial effusion. This patient's cardiac silhouette, although reduced by thyroid administration, did not return to normal size after several months of treatment. The work of Kern et. al.[3] suggests that pericardial effusion is the constant and major cause of the apparent cardiac enlargement.

The paucity of symptoms referable to the patient's edema and increased venous pressure gives rise to speculation. Obviously this was affected by the slowed cerebral function as manifested by clinical findings and the electroencephalogram. The reduction in cerebral oxygen consumption as shown to exist in this disease by Scheinberg et. al.[4] underlies the picture. The lack of symptomatology may also be attributed to the generally reduced oxygen consumption and the production of a degree of balance with diminished cardiac output. Also to be noted was the absence of signs of left ventricular failure.

The elevation and subsequent reduction of the venous pressure is poorly explained. A serious question remains as to whether such elevation is a reflection of myxedema.[5, 6] One might note that the existence of other cardiac disease has not been completely excluded. The role of bed rest and a 500mg. sodium diet is difficult to assess as regards the reduction in pressure.

The presence of effusion in areas other than the pericardial sac should not be surprising and has been reported previously. Mr. Means, considering autopsied cases, reports that in untreated cases the serious cavities "invariably contained fluid."[7]

The low rectal temperature was considered not only a part of the disease but a reminder of a frequent mode of death in myxedema: that is, the often fatal myxedema coma in which patients die hypothermic with body temperatures of 75 to 80 degrees. The subject is well covered in an editorial of the British Medical Journal.[8]

Treatment of myxedema should be carried out with caution. The precipitation of angina or myocardial infarction is a well recognized possibility. The patient presented here was begun on a slightly higher dose than is usually recommended but the principle of slowly increasing dosage by increments was observed. It should be emphasized that frequent electrocardiograms were done. Fortunately, increasing heart failure did not occur. It is interesting that some mental aberration was encountered but at least in this instance did not become serious. The advantages of our being able to follow this patient closely in the hospital are obvious.

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SPECIAL ARTICLES

Report on the Poliomyelitis Immunization Program in Kentucky*

October, 1955—April, 1958

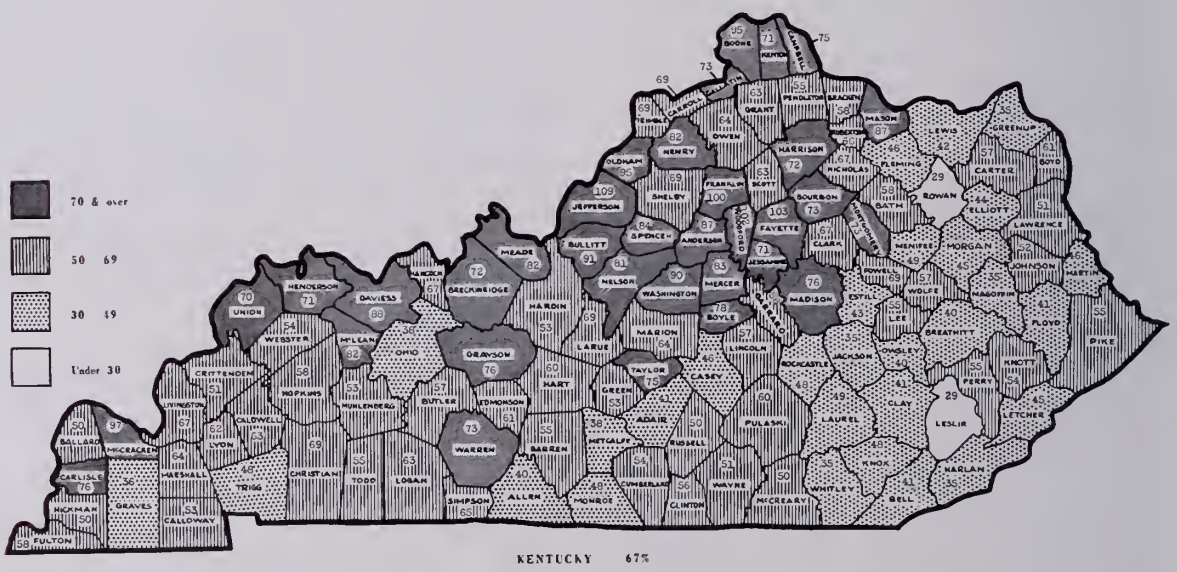
J. C. McGuire, M.D.,* Patricia K. Conlan, M.D.,**
Kathern Clay, B.S., M.S.***
Kentucky State Department of Health

THE first program in Kentucky for active immunization against poliomyelitis began in April, 1954, when Fayette and Jefferson Counties were selected to participate in the Poliomyelitis Vaccine Field Trials. The field trial experience was limited to voluntary participation of children enrolled in the second grade of public and parochial schools in the two counties. Three injections of vaccine was given, the last two at intervals of one and five weeks following the initial injection. In Jefferson County, all three injections were given to 6,118 children, and an additional 194 received only part of the series. In Fayette County, 1,118 children received the complete series, while 56 of the initial group failed to receive one or two of the injections.

A state-wide immunization program was subsequently undertaken in the spring of 1955, referred to as the National Foundation for Infantile Paralysis Program since the vaccine used was supplied without charge by that organization. Eligibility for the vaccine was limited to children in the first and second grades of school, comprising 180,726 according to enrollment figures. A tentative schedule calling for administration of the first injection of vaccine on April 25, the second on May 2, and the third on May 30 was adopted. Records on administration of the vaccine were kept locally, and complete information on this program is not available at the state level. However, according to a summary subsequently collected from local records, 124,777 children received immunizations under this schedule. The NFIP program thus covered 70% of the eligible group, or 11% of all children under twenty years of age in the state, based on the 1950 census.

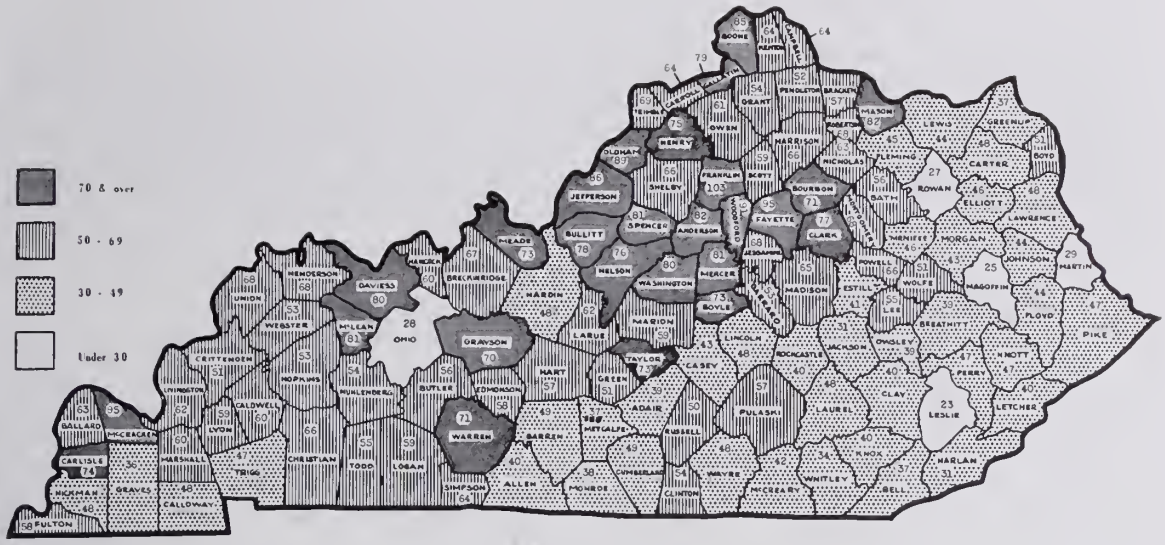
The third plan, known as the General Poliomyelitis Immunization Program, but usually referred to as the Federal Program, began with the passage by Congress of the Poliomyelitis Vaccination Assistance Act of 1955, which provided funds for the purchase and

* *Bureau of Medical Services.*
** *Division of Preventive Medicine.*
*** *Statistician.*



PERCENTAGES OF POPULATION UNDER TWENTY YEARS OF AGE REPORTED AS HAVING RECEIVED AT LEAST ONE INJECTION OF POLIOMYELITIS VACCINE, FOR KENTUCKY BY COUNTIES, THROUGH APRIL, 1958

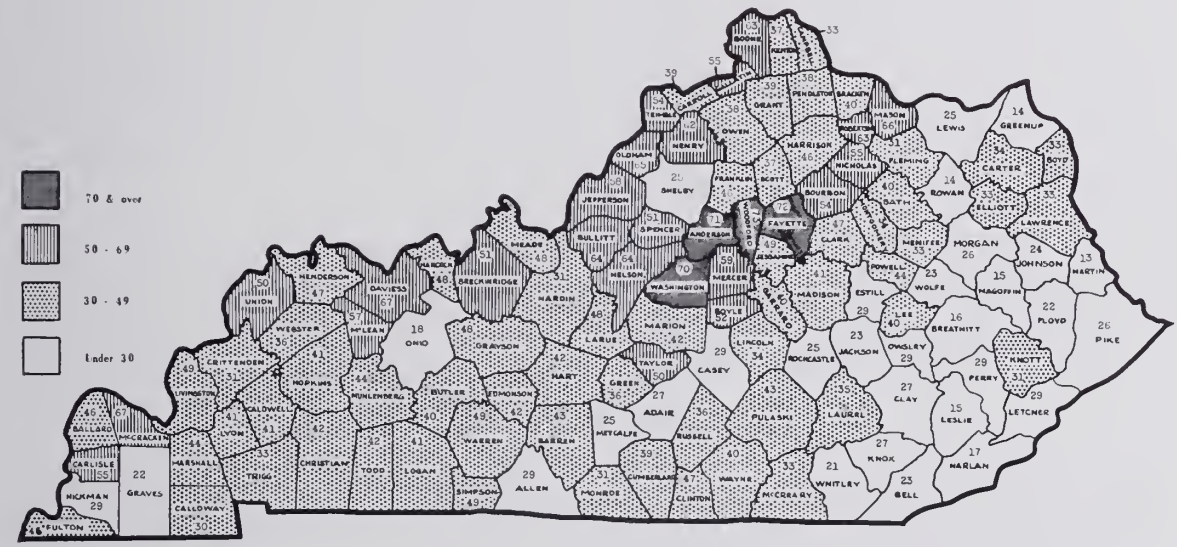
(Includes Field Trials of 1954, the NFIP Program and the Federal General Immunization Program.)



KENTUCKY - 59%

PERCENTAGES OF POPULATION UNDER TWENTY YEARS OF AGE REPORTED AS HAVING RECEIVED AT LEAST TWO INJECTIONS OF POLIOMYELITIS VACCINE, FOR KENTUCKY BY COUNTIES, THROUGH APRIL, 1958

(Includes Field Trials of 1954, the NFIP Program and the Federal General Immunization Program.)



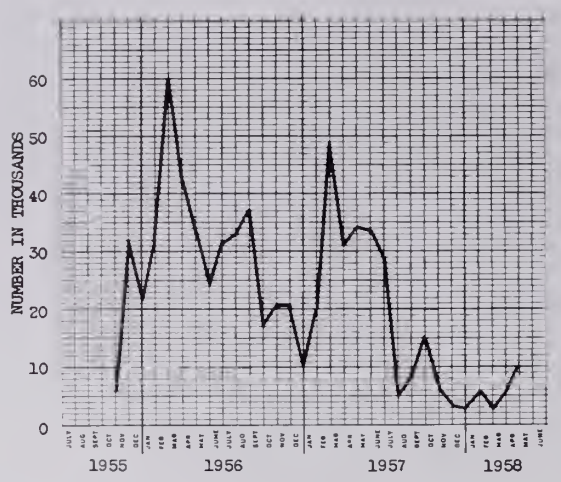
KENTUCKY - 40%

PERCENTAGES OF POPULATION UNDER TWENTY YEARS OF AGE REPORTED AS HAVING RECEIVED THREE OR MORE INJECTIONS OF POLIOMYELITIS VACCINE, FOR KENTUCKY BY COUNTIES, THROUGH APRIL, 1958

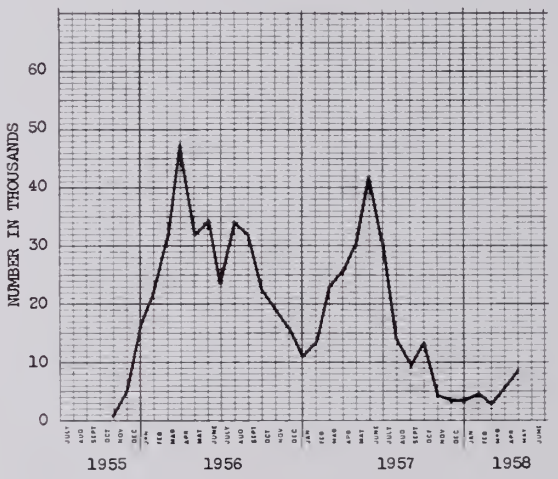
(Includes Field Trials of 1954, the NFIP Program and the Federal General Immunization Program.)

administration of poliomyelitis vaccine under regulations contained within the act. The first vaccine purchased under this Act was used in Kentucky in October of 1955. At first, usage was restricted to children one to nine years of age and pregnant women, but by January of the following year, the eligible group had been broadened to include all children under 20 years of age. The schedule of administration was changed to two injections at an interval of approximately one month, followed by a third given approximately seven months later. This series of three injections will be referred to as the "complete" series. Federal regulations required the reporting of each injection separately, by age groups for those under twenty and in total for pregnant women over twenty years of age. This detailed reporting makes possible the calculation of fairly accurate levels of immunization by age groups for the state as a whole as well as for the separate counties. It must be borne in mind, however, that for the lower age groups, an over-reporting will result from the accumulation of data which actually now covers a four-year total span. This over-reporting is offset to an unknown extent by the impossibility of inclusion of immunizations given with commercially-purchased vaccine, to which reference will be made later.

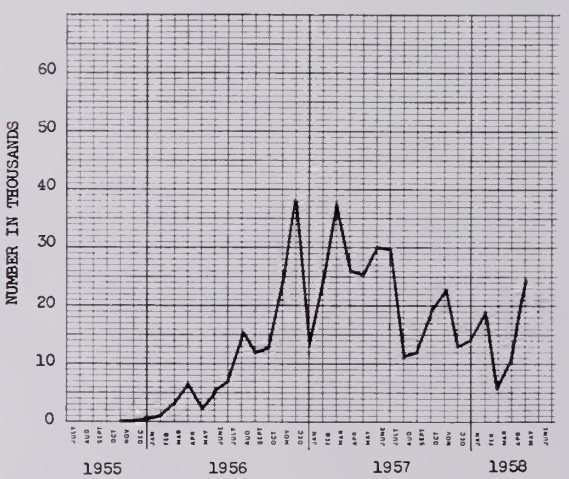
Through April, 1958, reports have been received on 1,754,929 injections, accounting for 95.1% of the vaccine purchased under the federal program. Of these injections, 640,773 represent first injections to



FIRST INJECTION



SECOND INJECTION



THIRD INJECTION

REPORTING OF POLIOMYELITIS INJECTIONS
OCTOBER, 1955 - APRIL, 1958

children under twenty years of age; 554,053 second injections; and 459,105 third injections in this age group. The remainder have been given to pregnant women over twenty years of age. For purposes of simplification in compiling statistics relating to the entire poliomyelitis immunization program, it has been assumed that children covered in the field trials and NFIP program received the equivalent of the present two injections separated by one month rather than the complete series of three injections including the final recall dosage administered after an interval of approximately seven months. Also for simplicity, these children have been tabulated in the five to nine age group, although it is known that some older children are found in the first two grades of school. With this combination of figures from the three programs, 66.9% of the children under twenty years of age have had at least one injection of poliomyelitis vaccine; 59.3% have had at least two injections; but only 40.3% have had the complete series of three injections.

Distribution of these percentages by county is shown on the maps on pages 66 and 67. There are thirty-three counties in the state in which 70% or more of the children under twenty have had at least one poliomyelitis immunization, but only four counties in which this percentage has had the complete series. In thirty-one counties, less than 30% of the children have had the complete series, but in only two counties have less than 30% had the first injection. Geographically, the best coverage has been achieved in the counties comprising the inner Bluegrass, and the poorest in the counties of eastern Kentucky. For first injections, urban counties are generally better covered than the average for the state, although for third injections this superiority is not so pronounced.

The time interval between the second and third injections does not fully account for the lag in coverage by the latter, since the peak of the program is well past, as may be seen from the attached chart showing the monthly reporting of first, second, third and total injections during the federal program (see graphs). Recurrent shortages of vaccine necessitating the postponement of third injections when due have undoubtedly contributed to the lag. Using the 1950 census as a population base, there are 383,190 children under twenty years of age in Kentucky who have had no injections of poliomyelitis vaccine, comprising approximately one-third of all children in this age group. An additional 86,914 children need two injections to complete the series, and 219,781 need the third injection. To this need for approximately 1,500,000 units of vaccine must be added the amount required to immunize the 70,000 babies born each year in the state. According to federal reports, approximately 600,000 units of vaccine have been released to commercial outlets within the state. It is obvious that some portion of this supply has been used to immunize children, but in view of the restriction of NFIP and federal vaccine to this age group, it is likely that the biggest demand for commercial vaccine has come from the adult population.

(Continued on Page 79)

EDITORIALS

Time To Get Our Feet Wet

ENLIGHTENED leaders in the medical profession are realizing more and more that physicians have just as much of a responsibility to help cure the social, economic ills of their patients as they do the physical ills of the patients. This being true, we, as physicians, must cultivate and increase our interest in civic and legislative affairs.

Many physicians would very likely welcome the opportunity to participate in civic affairs but are not sure as to how a start might be made. Perhaps a very pleasant, painless, but effective way to make such a beginning would be by applying for membership in your local and state Chamber of Commerce organization. First, let us consider what we may expect if we become affiliated with the Chamber of Commerce.

"In our early American days, the problems in the community that were not left completely to government were discussed in common meetings of the townspeople at the 'Ole Town Hall," said Thomas A. Ballantine, First Vice President of the Kentucky Chamber, in a recent address at the Louisville Kiwanis Club.

"In recent years, because of a change in the mode of living, the common meeting place became the schoolhouse. Here, business and professional men and women came to discuss their mutual problems and ambitions, and left outside their cloaks of selfishness in order to discover a common meeting ground for the things in which they were all interested.

"With the growth in population, redistricting of schools, etc., the schoolhouse has disappeared as the medium of this type of meeting. The one place for unselfish endeavor of the business and professional community rests within the Chamber of Commerce. These are only different in the problems and applications, whether they be on the local, state, or national level. This then is the voice of the business community. It is the vehicle by which business and professional people voice their hopeful aspirations, desires, and strive to find the right answer for their problems," Mr. Ballantine stated.

"A Chamber of Commerce is now a part of the American way of life, and it fills a unique and necessary portion of our way of life. A Chamber of Commerce is no longer a group that forecasts good weather and uninterrupted sales in the community. It is the voice of the business and professional community. It is the one place where business statesmanship can be felt to its greatest degree."

Relating Mr. Ballantine's comments to your own situation, you will, no doubt, be surprised to learn how many problems you have in common with your neighbors in other walks of life. You will enjoy your efforts in working with your neighbors in helping to solve these problems. Can you think of a better time to start than now?

George W. Pedigo, Jr., M.D.

Socialized Medicine: We Want None of It*

WE were more than dismayed when we opened our Sunday edition of the Louisville *Courier-Journal* recently, only to find a lead editorial which gave a glowing report of the British system of socialized medicine, and how the British people seemed to think it was something quite wonderful.

It was not clear from the reading of the editorial whether the *Courier* thinks that this same system should be adopted here in the United States; but frankly, we could think of no other reason for this particular subject occupying such a prominent position on its editorial page.

We have no quarrel with the *Courier's* right to publish any views it may hold. We simply

Reprinted from the Kentucky Farm Bureau News of September, 1958.

want to say that we are keeping and improving the most successful medical care system known anywhere in the world. We certainly are in no mood to follow the example of any of the socialist schemes in Europe where rationed poverty seems to be the reality as well as the goal of government planners.

It is preposterous that anyone would even think of substituting our system of medical care for any other, whether it be in England, Soviet Russia, Sweden, or what have you. Our private system is far from perfect, but it is the best known to man anywhere—bar none.

The do-gooders do a lot of talking and writing about the high cost of medical care, and try to give the impression that millions of Americans suffer and die from want of basic medical services. To be sure, we could use more doctors, more hospitals, and even lower cost for these services; but we do not believe that our doctors, nurses, technicians, specialists and hospitals deserve the gratitude of all of us. Our medical profession is not a static group. It is constantly seeking to improve its services to mankind. Look at the record of the Blue Cross-Blue Shield and other non-profit hospitalization and medical care plans. These plans were started by the doctors and hospitals who are interested in improving medical care in this country.

Instead of looking to the dismal failure of socialism as an answer to whatever health and medical problems we may have in this country, let's seek ways to constantly improve the system we have, and at the same time keep our medical profession free from the stranglehold of government. And while we are at it, let's keep a sharp eye out for schemes to achieve socialized medicine through the route of social security, veterans programs, or other devious means.

By the way, we are also against the government taking over the communication system in this country. In many countries in the world, newspapers have also been socialized "to better serve the people." We promise to be just as strong in our opposition to nationalizing the newspaper and broadcasting business as we are to socialized medicine. We suspect that the owners and editorial writers of the *Courier* will agree with us on this position.

**Opinions expressed in contributions to the Journal are those of the writers and do not necessarily reflect the views of the Ky. State Med. Assoc.*

Make your plans now to attend the

Ninth Annual

County Society Officers Conference

in

Lexington — Phoenix Hotel

March 26

ORGANIZATION SECTION

Co. Society Officers Conference Planned for March 26

A program for the ninth County Society Officers Conference to be held at the Phoenix Hotel in Lexington on Thursday, March 26, was approved at the last meeting of the Council of the KSMA.

The conference will deal, for the most part, with the problems brought about by the development of third party medical plans. Speakers from throughout the nation will be featured on the program, according to Robert W. Robertson, M.D., KSMA president.

Doctor Robertson invited all county society officers and committee chairmen and all KSMA committee chairmen to attend the conference, which is aimed at bringing them up-to-date on the problems facing medicine.

All county societies which have not already done so, were urged by Doctor Robertson to send the names of their county society officers and committees for 1958 to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky., so that they will receive a special invitation and program for the 1959 Conference.

Early Diabetes Returns Indicate Record Participation in '58

Returns on tests made during the 1958 Diabetes Detection Drive from all but 40 Kentucky counties indicate that the number of persons tested this year will exceed the 1957 total by a considerable amount, according to Robert J. Hoffman, M.D., South Fort Mitchell, Chairman of the Associate Committee on Diabetes.

As the Journal went to press, reports from 53 counties had been received indicating that 51,973 persons had been tested. In 1957 the complete total was 52,400 tested in 83 counties.

In this drive to date 131 newly proved diabetics have been discovered, with 680 positive urine sugar tests, and a total of 256 proved diabetics tested. In the 1957 drive 137 new diabetics were discovered.

During 1958 a concerted effort was made to obtain greater physician participation in the drive. This was the eighth drive conducted by the KSMA in cooperation with the American Diabetes Association.

Members of the KSMA Associate Committee on Diabetes are: Doctor Hoffman, chairman; Herald K. Bailey, M.D., Ashland; George P. Carter, M.D., Louisa; Marcus A. Coyle, M.D., Springfield; Thomas J. Crume, M.D., Owensboro; Albert H. Joslin, M.D., Beaver Dam; Franklin B. Moosnick, M.D., Lexington; Stanley T. Simmons, M.D., Louisville; Arthur T. Hurst, M.D., Louisville; and Esten S. Kimbel, M.D., Frankfort.



The Clinitron saw action at both Baptist and St. Anthony's Hospitals in Louisville during the 1958 Diabetes Detection Drive. Shown at St. Anthony's are: (left to right) Edwin Cameron, M.D., of the State Department of Health; Jack Mulligan, M.D., Louisville, head of the Jefferson County Diabetes Detection Drive; Sister Albertinia, head of the St. Anthony's laboratory; Roberta Baumgardner, laboratory technician; and Sterling Harrison, Louisville, who is being tested for Diabetes.

Dr. Gundersen Urges Action on Problems of the Aging

Urging that medicine fight hard to preserve basic principles and traditions essential to good medical care, Gunnar Gundersen, M.D., LaCrosse, Wisconsin, president of the American Medical Association, in his address at the opening session of the AMA House of Delegates, 12th Clinical Session in Minneapolis on December 2, also stressed the need for alertness and adaptability to the changing times in which we live.

He called health care of the aged "one of the most immediate and compelling problems" facing medicine today. He said that this problem has been created by physicians and health workers who have provided improved medical care, better health, and longer life. Doctor Gundersen said that now they must accept responsibility for solving the medical and socio-economic issues raised by the increasing number of senior citizens.

Doctor Gundersen lauded the work of the AMA Committee on Aging, urging that every state and sizeable county set up such a committee, and outlined the six-point program of the AMA Committee on Aging to mobilize and coordinate medical society action.

Following is the six-point program presented at the September meeting of the committee.

1. Stimulation of a realistic attitude toward aging by all people.

2. Extension of effective methods of financing health care for the aged.

3. Expansion of skilled-personnel training programs and improvement of medical and related facili-

ties for older people.

4. Promotion of health maintenance programs and wider use of restorative and rehabilitative services.

5. Amplification of medical and socio-economic research in problems of the aging.

6. Leadership and cooperation in community programs for senior citizens.

He cited the work of the Joint Council to Improve the Health Care of the Aged and its study of the needs of the aged, and also mentioned the AMA support of legislation during the last session of Congress which stimulate the construction of more nursing homes and chronic illness facilities, and of the bill calling for a White House Conference on Aging to be held in January, 1961.

"Many activities are underway," he said, "but they must have full, vigorous implementation all the way from the House of Delegates and AMA Headquarters down to the grass roots."

E. W. Jackson, M.D., Paducah, Dies: Former KSMA President

E. W. Jackson, M.D., Paducah surgeon, and former President of the Kentucky State Medical Association, died following a heart attack at Riverside Hospital in Paducah.



Doctor Jackson served as Association president from 1946-7 after serving two years as vice president. In 1954 he was awarded the Association's Distinguished Service Award.

A native of Hickman County, Doctor Jackson was graduated from the University of Louisville School of Medicine in 1912. He interned at City Hospital in Louisville before coming to Paducah to begin practice in 1914. He was a captain in the U. S. Medical Corps during World War I.

Doctor Jackson has also served as president of the McCracken County Medical Society and the Kentucky Surgical Society. He has served on numerous committees in the field of medical organization, both on the state and national level.

Committee Makes Preliminary Plans for 1959 Annual Meeting

Preliminary plans for the 1959 KSMA Annual Meeting in Louisville on September 22, 23, and 24 indicate that it will provide Kentucky physicians with a program of high caliber postgraduate medical education, according to R. W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements.

First meeting of the committee, at which the annual session plans were outlined, was held in Louisville on November 20, with Doctor Robertson presiding.

"Panel discussions, a clinicopathological conference, and feature presentations by top notch speakers from throughout the U. S. will highlight the 1959 meeting," Doctor Robertson said. Scientific and technical exhibits will also be part of the program as in the past, according to Doctor Robertson.

Specialty group meetings have again been scheduled for Wednesday afternoon. Presidents of the 13 groups participating in the annual meeting will meet with Doctor Robertson and other members of the Committee in the Saddle Horse Room of the Brown Hotel on January 22.

Color television programs, which have been on the annual meeting program for the past two years, will not be on the program of the 1959 meeting. This will enable more "in person" talks by authorities in various medical fields, and it is expected that there will be additional panels and individual presentations this year.

Members of the Committee on Scientific Assembly and Arrangements include: Doctor Robertson, chairman; Irvin Abell, Jr., M.D., Louisville, vice chairman; Kenneth L. Barnes, M.D., Princeton; G. F. Brockman, M.D., Greenville; Frank L. Duncan, M.D., Monticello; Everett L. Pirkey, M.D., Louisville, and Beverly T. Towery, M.D., Louisville.

Medical Care Commission's Report to Supplement AMA Journal

The 96-page report of the AMA's Commission on Medical Care Plans will appear as a supplement to the Journal of the AMA late in January or early in February, F. J. L. Blasingame, M.D., executive vice president of the AMA told the Headquarters Office at press time.

KSMA Secretary Woodford B. Troutman, M.D., Louisville, urges all KSMA members to read this important document, giving special emphasis to Sections 3, 4, and 5.

This report was presented at the AMA House of Delegates meeting in Minneapolis on December 2. On December 4, the House accepted the Reference Committee Report that no action be taken on it until the June meeting in Atlantic City. It further requested all state associations to submit their views on the report to the AMA Headquarters Office two months prior to the June meeting, Doctor Troutman said.

See the report on the meeting of the AMA House of Delegates on page 73.

Dr. Robertson to Speak at Meet of 11th Councilor District

"This is Your KSMA" is the title of the talk which Robert W. Robertson, M.D., Paducah, KSMA president, will make at the meeting of the Eleventh Councilor District at the Winchester Country Club on Tuesday evening, February 10, according to Joe Bush, M.D., Mount Sterling, Councilor for the Eleventh District.

K. Armand Fischer, M.D., Louisville, will present the scientific portion of the program with an illustrated lecture on "Low Back Pains." The meeting will begin with a social hour at 5:30 p.m. (CDST) followed by dinner at 6:30 p.m.

Host group at the meeting will be the Clarke County Medical Society. The president and secretary of the Society are cooperating with Doctor Bush in arranging the meeting. Wives are invited to attend.

William E. Rudd Joins KSMA Staff As Executive Assistant

William E. Rudd, a native of Hopkins County, has been appointed executive assistant of the Kentucky State Medical Association, according to an announcement from Robert W. Robertson, M.D., Paducah, KSMA president.



Mr. Rudd, who took over his new duties on December 8, is a graduate of Bowling Green Business University in 1950 with a B. S. in higher accounting and business administration.

As executive assistant, Mr. Rudd will assist the executive secretary with the administration of the Headquarters Office and will work with various Association committees, including, the Committee on Public Information and Service, the Committee on Medical Education and Economics, Committee on Medical Services, Committee on Allied Professions, and the Committee on Federal Medical Services.

He was formerly associated with coal mining interests in western Kentucky, both in office administration and direct coal production. His past experience includes work as a field auditor for the Texas Gas Transmission Corporation in Owensboro and with the U. S. Treasury Department in Louisville and Bowling Green as internal revenue agent examining officer.

Mr. Rudd served from 1943 to 1946 with the U. S. Army in the European theater. He is married and has two children, Cheryl, 7, and William E., Jr., 3.

Health Care of Aged Highlights Discussion in AMA House

Health care of the aged and the report of the Commission on Medical Care Plans highlighted the issues acted on by the House of Delegates of the American Medical Association at its twelfth interim meeting in Minneapolis, December 2-5.

W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, represented the KSMA at this busy and historic session which was keynoted by addresses of AMA President Gunnar Gundersen, M.D., LaCrosse, Wis., and the Governor of Minnesota, the Honorable Orville L. Freeman. Doctor Pierce served on the Reference Committee for Military Medical Affairs.

Health Care of Aged

On the subject of health care for the aged, the House of Delegates, without debate or dissenting vote, accepted the recommendation of the Council on Medical Services which read: "That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income; that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

In order to effect the immediate implementation of such a program, the House directed that copies of the proposal be distributed to medical society approved plans, including Blue Shield and private insurance programs, requesting their cooperation.

Medical Care Plans

The report of the four-year study of the Commission on Medical Care Plans was debated for two hours in Reference Committee where Doctor Long and KSMA Alternate Delegate George Archer, M.D., Prestonsburg, testified. The House adopted the Reference Committee statement on this highly important study which read:

"We respectfully suggest to the constituent associations reviewing the report in the interim, that their attitude regarding the report will be clarified if they arrive at some decisions in regard to the following basic points:

"1. *Free Choice of Physician*—Acknowledging the importance of free choice of physicians, is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualification?

"2. *Closed Panel Systems*—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

"These suggestions acknowledge that the policy of the American Medical Association to encourage and support the highest quality of medical care for all patients remains unchanged. They question, however, whether attitudes toward the free choice of physician and the closed panel system may be undergoing evolutionary change."

The House recommended that the Board of Trustees invite the constituent associations to forward their replies to these questions to the Executive Vice President 60 days in advance of the June, 1959, meeting.

The House approved a statement by the Council on Medical Education and Hospitals supporting the development of additional facilities for basic medical education, and it urged the entire profession to give that policy strong support in order to correct misinterpretations of the Association's viewpoint regarding the supply of physicians.

Administrative Changes

Extensive changes proposed by the Board of Trustees in the administration structure of the AMA to revitalize and make more effective the operation of the Headquarters Office in Chicago and the AMA Washington Office, were heard and approved by the House. It was also announced that the Board of Trustees had elevated the status of the Committee on Legislation to that of Council on Legislation. The new Council "will undertake an enlarged, strengthened legislative program, closely coordinated with activities of the new field staff and the Washington office."

In considering basic programs and objectives of the AMA, the House recommended that the Board

of Trustees establish a mechanism which will assume the responsibility for promoting active liaison with each national medical society. "In the scientific fields," the House declared, "the role of the AMA should be primarily that of leadership, but every endeavor should be made to bring about coordination of the special fields of scientific interest of the other national medical organizations." The delegates also approved a recommendation that the Board of Trustees give serious consideration to opening the publications of the Association to a free and open discussion of socio-economic problems applicable to medicine.

Other Actions

Other actions of the AMA House included: notice of the restrictive changes in the Medicare program and a recommendation for the reestablishment of services under the free choice principle in areas where federal facilities have been substituted for private care; and a recommendation that the Social Security Act be amended by Congress to permit states to combine the present four Public Assistance medical programs into a single medical program.

The House also authorized the Council on Medical Service to sponsor a Congress on Prepaid Health Insurance; approved a plan to develop "buyer's guides" to send to physicians to help patients analyze the merits of health insurance programs; and voted to allow dues exemptions for interns and residents in training programs approved by the Council on Medical Education and Hospitals.

It called to the attention of those responsible for intern and resident training that medical services provided to patients in hospitals are the responsibility of duly licensed physicians; agreed that relative value studies should be conducted by each constituent medical association but not on a national or regional basis by the AMA; and called for continued activity to stimulate development of effective poliomyelitis programs.

AMA to Request McDowell Stamp Issued in 1959

The House of Delegates of the American Medical Association went on record as approving a resolution that the Association request the Post Office Department to issue an Ephraim McDowell—Jane Todd Crawford Memorial Stamp in 1959 commemorating the 150th anniversary of the first successful oophorectomy.

KSMA leaders and Kentucky's two U. S. Senators —Thruston B. Morton and John Sherman Cooper— have been working for months toward the issuance of such a stamp.

Introducing the resolution for Kentucky at the final session of the AMA House were: W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville, Kentucky's delegates to the AMA.

The first recorded oophorectomy was performed by Ephraim McDowell, M.D., on December 25, 1809 at Danville, Kentucky on Jane Todd Crawford. It is felt that the AMA approval of such a stamp will lead to favorable consideration of it by the U. S. Post Office Department.



Talking things over following the dedication of the new Kentucky Blue Cross-Blue Shield building in Louisville are Lane Tynes (left), president of the Kentucky Blue Cross and executive director of Kentucky Physicians Mutual, and J. Vernon Pace, M.D., Paducah, president of Kentucky Physicians Mutual.

Blue Cross-Shield in New Building on Bardstown Road

Kentucky Blue Cross-Blue Shield began operations in its new office at 3101 Bardstown Road, Louisville, on November 24, held a formal dedication on December 1, and an open house on December 12.

The remarkable growth experienced by the plans since moving into their former location on West Main Street in 1950 and the need for more space necessitated their move. According to J. Vernon Pace, M.D., Paducah, president of Blue Shield Board and James P. Miller, Louisville, chairman of the Blue Cross Board, the building will enable them to continue their low operating costs and at the same time increase efficiency.

The Boards have estimated that the entire building project can be paid for in less than ten years by funds which would have to be used for leasing at present rental cost. The new building, a one floor plan with a two-story Colonial brick front, contains approximately 41,000 feet of floor space.

Dr. Bishop Honored by 250 Jeffersontown Citizens

More than 200 people crowded into the Jeffersontown Community Center on Friday evening, December 19 to show their appreciation and pay their respects to J. Auldin Bishop, M.D., who had served them as physician for the past 24 years.

The demonstration, which came as a complete surprise to Doctor Bishop, was carefully planned by local citizens. Among the gifts presented to Doctor Bishop was a check for $2300 with a citation which read in part, "to apply on furnishing the fine new office of our faithful doctor." The money was contributed by the citizens of Jeffersontown.

Doctor Bishop graduated from the University of Louisville School of Medicine in 1933 and interned at St. Elizabeth Hospital in Covington.



The new home of Kentucky Blue Cross-Blue Shield—designed to assure maximum efficiency and minimum cost of operation and to provide for future growth—is located at the intersection of Bardstown Road and the Watterson Expressway in Louisville.

Dr. Chambers Re-elected President of Kentucky Medical Foundation

J. S. Chambers, M.D., Lexington, was re-elected to the presidency of the Kentucky Medical Foundation, Inc., at a meeting of the KMF Board of Directors in Lexington on December 4. J. Farra Van Meter, M.D., Lexington, was elected a vice president of the Foundation.

KSMA members named to the executive committee are C. C. Johnston, M.D., and Francis M. Massie, M.D., both of Lexington. Named directors with terms expiring in 1959 were: Virgil Kinnaird, M.D., Lancaster; and Richard R. Slucher, M.D., Buechel. Paul B. Hall, M.D., Paintsville, is a director with a term expiring in 1961.

Doctor Chambers reported that a finance committee is being organized so that the foundation, which has as its major task the support of the University of Kentucky Medical Center, can have continuing operational funds. The directors voted to establish relations with the University of Louisville Medical Foundation, a similar group concerned with supporting the U of L Medical School.

AHA President-Elect to Speak at Heart Assoc. Symposium

A. Carlton Ernstene, M.D., Cleveland, Ohio, president-elect of the American Heart Association, will be the dinner speaker during the Fifth Annual Symposium on Cardiovascular Diseases on the Roof Garden of the Brown Hotel, Louisville, on March 11 and 12.

Doctor Ernstene's topic will be "The Clinical Spectrum of Coronary Heart Disease." The two-day program will also feature scientific presentations by 12 specialists in the cardiovascular field according to George W. Pedigo, M.D., chairman of the Symposium.

Sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine, the program has been accepted by the American Academy of General Practice for 11 credit hours. Registration will be $6.00 a day.

"Ky. Business" Salutes Medicine

The December issue of "Kentucky Business," publication of the Kentucky Chamber of Commerce, carried articles on medicine in Kentucky. One saluted the KSMA's Rural Kentucky Medical Scholarship program and the other traced Kentucky medicine from pioneer times to the present in an item entitled, "Great Medicine." The Council of the KSMA has expressed its appreciation to the Chamber for giving its readers this information. The cover of the magazine depicted Doctor McDowell welcoming Jane Todd Crawford upon her arrival before the world famous operation.

Sixth District Elects Officers

Rex Hayes, M.D., Glasgow, was elected president of the Sixth Councilor District at a meeting of the District in Bowling Green. He succeeds Lillard F. Beasley, M.D., Franklin. Other officers elected for 1959 at the meeting were Carlisle V. Dodson, M.D., Russellville, vice president, and Waller H. Griffing, M.D., Bowling Green, secretary-treasurer.

Rural Health Conference Attended by 140 Kentuckians

Approximately 140 Kentuckians attended the sixth annual Rural Health Conference in Louisville on December 4, according to Wyatt Norvell, M.D., chairman of the Kentucky Rural Health Council which sponsored the meeting.

Twenty organizations were represented by those attending the meeting. Those having the greatest number of representatives there were: Golden Age Club, 26; State Department of Health, 22; KSMA, 11; Farm Bureau Federation, 8; Extension Service, 6; Pharmaceutical Association, 6; Kentucky Utilities, 5; and Woman's Auxiliary to the KSMA, 5.

A special feature of the conference was a talk by Leonard Read, Ph.D., President of the Foundation for Economic Education, Inc., Irving-on-Hudson, New York, on the "Essence of Americanism." Other parts of the program had to do with poison control, problems of the aged, and the transmission of disease from animals to man.

Mitchell B. Denham, M.D., Maysville, chairman of the KSMA's Committee on Rural Health, was elected chairman of the Rural Health Council to succeed Doctor Norvell. Other officers elected at the meeting were: E. M. Josey, Frankfort, executive secretary of the Kentucky Pharmaceutical Association, vice chairman; and Mrs. T. L. Roberts, Kentucky Farm Bureau Federation, Louisville, secretary and treasurer.

The Rural Health Council was founded by the KSMA in 1951. It has 22 member organizations.



Top left

Wyatt Norvell, M.D., New Castle, chairman of the Kentucky Rural Health Council, accepts a glass of milk from the Dairy Princess, Ann Kelly, at the American Dairy Association free milk bar at the Rural Health Conference as John Moser, assistant secretary-treasurer of the ADA, watches.

Bottom left

Participants in a panel discussion on "Remaining Useful in Advanced and Retirement Age" at the afternoon session of the Rural Health Conference at which Vio'a Hansen, Lexington, presided were: (left to right) J. E. Stanford, Louisville; Miss Hansen; Herman L. Donovan, Ph.D., Lexington; Myrtle Weldon, Lexington, moderator; Robertson O. Joplin, M.D., Louisville; and Earl Mayhew, Lexington.

Top right

Listening to a talk by Leonard Read, Ph.D., on the "Essence of Americanism" at the sixth annual Rural Health Conference are (left to right) James S. Williams, M.D., Nicholasville; John Moser, Louisville; Mitchell Denham, M.D., Maysville; Margaret Kelly, R.N., New Castle; Howard Downing, Nicholasville; and Robert H. Singer, D.V.M., Frankfort.

Bottom right

Newly elected officers of the Rural Health Council—Mitchell B. Denham, M.D., Maysville, chairman; Mrs. Thomas Roberts, director of Kentucky Farm Bureau Women, secretary-treasurer; and E. M. Josey, executive secretary of the Kentucky Pharmaceutical Association, vice chairman—got together at the Rural Health Conference in Louisville on December 4.

Inset pictures are of speakers—left—Charles Walton, Ph.D., U of K, and right—John Koon of the Farm Bureau.

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STUDENT AMA

Thanks . . . . .

Throughout the student years in medicine there is a group of men who rarely are taken into consideration when the "experts" talk about medical education, but who are constantly in contact with students and actually form in large measure the medical character of the student physician. This group is composed of every practicing physician with whom the student has academic, social, or personal relationships.

First are the dedicated "outside men" who give freely of their time and experience as lecturers and conference advisors with the actual curriculum of medical school. By and large it is from these men that the student learns the most valuable lessons in medicine. These are the ones who give the student the insight necessary for dealing with the patient in private practice. From their frank relating of their own mistakes in practice the student learns painlessly to avoid those things which might later bring him grief. It is from them that one learns the time-honored remedies that are so often overlooked in this age of antibiotics and steroids.

Second is a larger group of men who have no official connection with an organized teaching program. These are the physicians whom the students meet in the hospitals or those who serve as unofficial preceptors in the student's home town.

The medical student of today works in addition to going to school. This is now much more generally true than in the past. The physicians in the hospital where he works determine to a great extent the attitudes and medical methods which he may use in the future. The time spent by these men in discussing interesting cases with the working student is invaluable and a word of encouragement or praise from such a physician works wonders to spur the externe or technician to greater excellence in the performance of his duties.

Some of the most beneficial experiences in the life of a medical student are those gained in the office of an interested physician friend. These men occasionally invite the student to spend a day or part of one in their offices. Here the student may see the physician in action and often is allowed to assist in the practice. Such interest is never without reward in the form of near adulation on the part of the student.

In the beginning of this new year those of us who have received so much from those of you who have given so freely, wish to express our humble gratitude for your unceasing patience and untiring efforts in our behalf. Surely, with such predecessors to emulate we cannot go far astray from the ideals of our profession.

Neville Caudill
President, U of L Chapter
Student AMA

Austin Smith, M.D., Resigns As AMA Journal Editor

Austin Smith, M.D., resigned as editor of the Journal of the American Medical Association in November after 9 years as editor and 18 years with the Association. J. F. Hammond, M.D., associate editor of the Journal, has taken over Doctor Smith's duties.



In a brief memorandum to the AMA Board of Trustees, Doctor Smith asked that he be relieved of his editorial responsibilites on December 15. He said that it is his conviction that there is need for "new blood" in key administrative positions and although he has no immediate plans, he hopes to take a much needed vacation.

In accepting Doctor Smith's resignation, F. J. L. Blasingame, M.D., executive vice president of the AMA expressed the Association's regret at his resignation and its appreciation for his many years of service. Dr. Smith became Editor of the Journal in 1949.

County Society Reports

McCracken

The regular monthly meeting of the McCracken County Medical Society was held at the Cobb Hotel in Paducah on October 22, according to Vernon D. Pettit, M.D., secretary. Burton Haley, M.D., presided.

Herbert L. Clay, Jr., M.D., professor of medicine, University of Louisville School of Medicine, was featured on the program. He discussed the heart as it interests the general practitioner, with particular emphasis on the various types of drugs to use in cardiac emergencies.

The Society passed a resolution that it "strongly approves and wholeheartedly endorses the proposed program for fluoridation of the water supply of the City of Paducah." And, voted that the resolution be forwarded to the local dental society. This resolution received the unanimous vote of the Society.

A motion was made to amend the Society's constitution to read, "June, July, and August" rather than "July, August, and September." Another motion was made and passed unanimously that the society defray the expenses of installing a telephone in the press box at the Stadium during the football season.

Rex Holland, M.D., announced that the mental health clinic is now in operation and a psychiatrist visits the clinic five days a month. There are approximately 80 patients now being seen in the clinic. He stated that the care in the clinic at the present time is limited, but is expected to be broadened in approximately two to three years.

Norman A. Parrott, M.D., health officer of the Paducah-McCracken County Health Department announced that there are some fields in the Health Department in which some guidance is needed. He

stated that some steps should be taken by the Society to take care of indigent people who do not qualify for city or county care. He said that the dental society had worked out an arrangement for seeing these people on an alphabetical basis and said he would welcome suggestions.

He also announced that 3/5 of the approximately 11,000 school children in the city and county have had all three polio immunizations. He said approximately 1/5 have had none and 1/5 have had only partial immunizations. There is no polio vaccine available in the health department and no funds for the purchase of vaccine. Much discussion followed although no solution was obtained.

SPECIAL ARTICLE—POLIO

(Continued from Page 68)

No statistics are available on coverage of the adult population, comprising approximately 1,800,000 individuals, with 850,000 in the age range from twenty to thirty-nine years.

Within the age group under twenty years, the most successful coverage for first and second injections has been reached in the five to nine year ages, with 83.5% and 80.5% respectively having had first and second injections. For the complete series, the highest coverage is in the ten to fourteen age group, with the five to nine group next. Percentages are 50.8 and 46.4 respectively. These results are consistent with the restrictions on use of NFIP vaccine with which the program was begun, since a number of the children who initially received immunizations with this vaccine would have progressed to the next age group by the time recall injections of federal vaccine were administered. Percentages of children under twenty years of age are shown in the tables on page excluding those which could not be fitted into the age grouping selected.

Of the total injections reported as given under the federal program, approximately one-third (32.3%) were administered by physicians in the course of their private practices, while the remaining two-thirds were given under health department auspices. Since physicians throughout the state cooperated with the entire immunization program, injections reported in the latter group in a good many instances were actually administered by private physicians who volunteered their services in health-department sponsored clinics. Although the failure to obtain more complete coverage, especially with the full series of three injections, must be deplored, the actual accomplishments achieved within the relatively short time are a monumental tribute to the effectiveness of wholehearted cooperation along the medical profession, private organizations, and federal, state and local public health agencies. The impact of this cooperation on public health in Kentucky has already become apparent, and will become increasingly so when expected epidemics of poliomyelitis are successfully avoided. The effect of this program during the past 1958 "polio season" is discussed at length on the Public Health Page of this January issue of the KSMA Journal.



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Norton PG Seminar Attended by 115

One hundred fifteen physicians from Kentucky and southern Indiana attended a day-long postgraduate seminar at Norton Memorial Infirmary in Louisville on December 18, according to Robert Lich, Jr., M.D., president of the Norton Memorial Infirmary staff who expressed his pleasure at the "turn out" for the meeting.

The entire collection of papers presented at the meeting was prepared in booklet form and distributed to those attending. Doctor Lich said that the trustees of Norton's have voted to make it an annual event. This year's seminar was sponsored by the Infirmary in conjunction with the Kentucky Chapter, American Academy of General Practice.

Yandell Award to Dr. Zollinger

Robert M. Zollinger, M.D., head of the department of surgery at Ohio State University and first vice president of the American College of Surgeons, received the Louisville Surgical Society's David W. Yandell Medal at a dinner meeting of the Society on November 25.

Doctor Zollinger delivered the annual Yandell lecture at General Hospital and spoke before the Society at a dinner at the Standard Country Club that night. His topic as the Yandell Lecture was "Pancreatitis."

Easter Seal Drive Starts in March

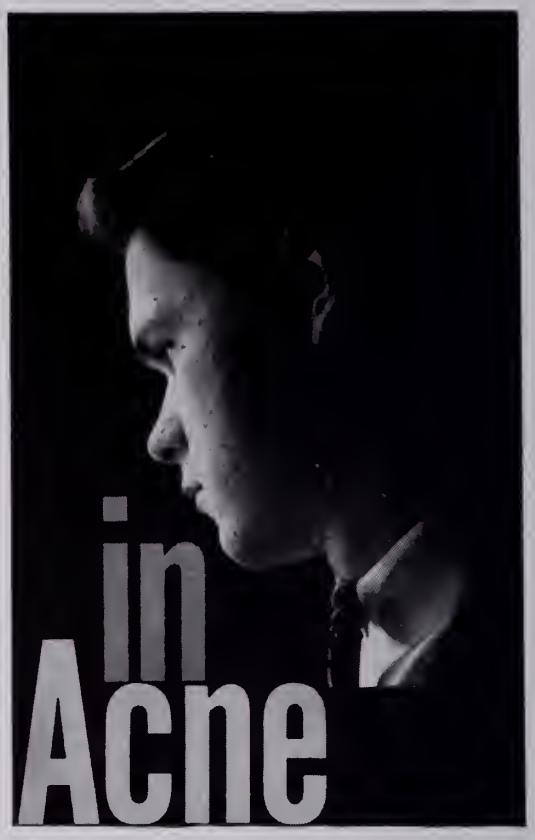
The Kentucky Society for Crippled Children already has its plans well underway for the 1959 Easter Seal Campaign scheduled for the month of March. A voluntary, non-profit organization providing funds, centers and personnel to help children and some adults who are crippled, the Society is supported through contributions received through the Easter Seal Appeal and by special gifts, donations, and bequests.

Through the support of more than 100,000 Kentuckians and the help of more than 8,000 volunteers, the Society provided direct services for 3,877 children and adults last year. In cooperation with other agencies indirect services reached an additional 3,375 persons.

Library Fund Drive Underway

The Louisville Medical Library is making its fifth annual appeal to aid the Louisville Medical Library, a joint facility provided by the Jefferson County Medical Society and the University of Louisville. Chairman of the library committee is Sidney I. Kornhauser.

In 1958, the friends of the medical library contributed $2,555—about $100 more than in 1957. There are three classes of donors: patrons who contribute $100 or more; fellows who contribute $25 or more; and sustaining members who contribute $10. Checks should be made out to the Louisville Medical Library and sent to the Jefferson County Medical Society.



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Co. Soc. Honors Dr. Mersch

Edward B. Mersch, M.D., Covington, was guest of honor at a surprise dinner given by the Campbell-Kenton Medical Society at Summit Hills Country Club on December 4. Doctor Mersch, retiring president of the society, was presented with three orchid plants by Robert Hoffman, M.D., South Fort Mitchell, newly elected president.

Pediatrics Academy Elects Fellows

Two Kentuckians — Leslie W. Langley, M.D., Somerset, and Fred Pipkin, M.D., Louisville—were elected fellows of the American Academy of Pediatrics at a meeting of the group in Evanston, Illinois. They were among 154 physicians who were made Fellows at the meeting.

Surgeons Give to McDowell Home

The American College of Surgeons has contributed $500 to the McDowell Home and Apothecary, Danville, in memory of the late Daniel C. Elkin, M.D., Robert W. Robertson, M.D., Paducah, KSMA president has announced.

The check was received just before Christmas from Paul W. Hawley, M.D., director of the American College of Surgeons. President Robertson expressed the Association's appreciation for the generous contribution.

Urologists to Meet in Louisville

The Southeastern Section of the American Urologic Association will meet at the Brown Hotel in Louisville from March 29 to April 2, according to Robert Lich, general program chairman, Louisville. Eight states are included in this section. Doctor Lich expects about 400 physicians to attend.

NEWS ITEMS

Jerry Milton Shaw, M.D., a graduate of Tulane University School of Medicine in 1954, is now associated with A. Clayton McCarty, M.D., Louisville, in the practice of internal medicine. Doctor Shaw is a native of Pine Bluff, Arkansas. He took his internship and residency training at Charity Hospital in New Orleans and had a teaching fellowship of one year at Tulane.

John E. Haynes, M.D., has become associated with the Trover Clinic in Madisonville where he will limit his practice to anesthesiology. A native of Calhoun, Kentucky, he graduated from the University of Louisville School of Medicine in 1933. He interned at St. Elizabeth Hospital in Covington in 1933-34. He took his residency in anesthesiology at the University of Minnesota Hospitals, Minneapolis from 1956-58.

Clifton E. Lowry, M.D., has started the practice of general surgery in Owensboro. A graduate of the University of Louisville School of Medicine in 1953, he interned at Portsmouth Naval Hospital in Virginia from 1953-54 and took his residency training at VA Hospital in Buffalo, N. Y. He served as a lieutenant (jg) in the U. S. Navy. He is a native of Marion, Ky.



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Iowan Named GP of Year by AMA

Lonnie A. Coffin, M.D., Farmington, Iowa, was named the twelfth recipient of the AMA's "General Practitioner of the Year" Award by the House of Delegates on December 2. He is the first Iowan to receive the award.

Doctor Coffin was presented a gold medal and citation outlining his contributions by Louis M. Orr, M.D., Orlando, Fla., AMA President-Elect. The award is given each year to the doctor who typifies the thousands of general practitioners who dedicate their lives to the practice of medicine and exceptional service to their communities. Selected as Iowa's Outstanding GP in April, Doctor Coffin was lauded for his community interest, professional services, and his friendship.

MATERNAL MORTALITY

(Continued from Page 18)

during this time, but while we are medicolegally responsible for the administration of blood typed by someone else incorrectly it is our direct obligation to stop the bleeding. In this case possibly hysterectomy or ligation of the uterine or hypograstic arteries should have been done if other measures such as pitocin infusion, calcium gluconate, inspection of lacerations failed to control the bleeding. The fact that the bleeding finally was controlled would suggest in retrospect hysterectomy wouldn't have had to be done, however, earlier it might have eliminated the rather large amount of blood needed.

In any event this was a direct obstetrical death that certainly was preventable. If the Coombs test was done before the patient was transfused this incompatibility should have been detected and prevented.

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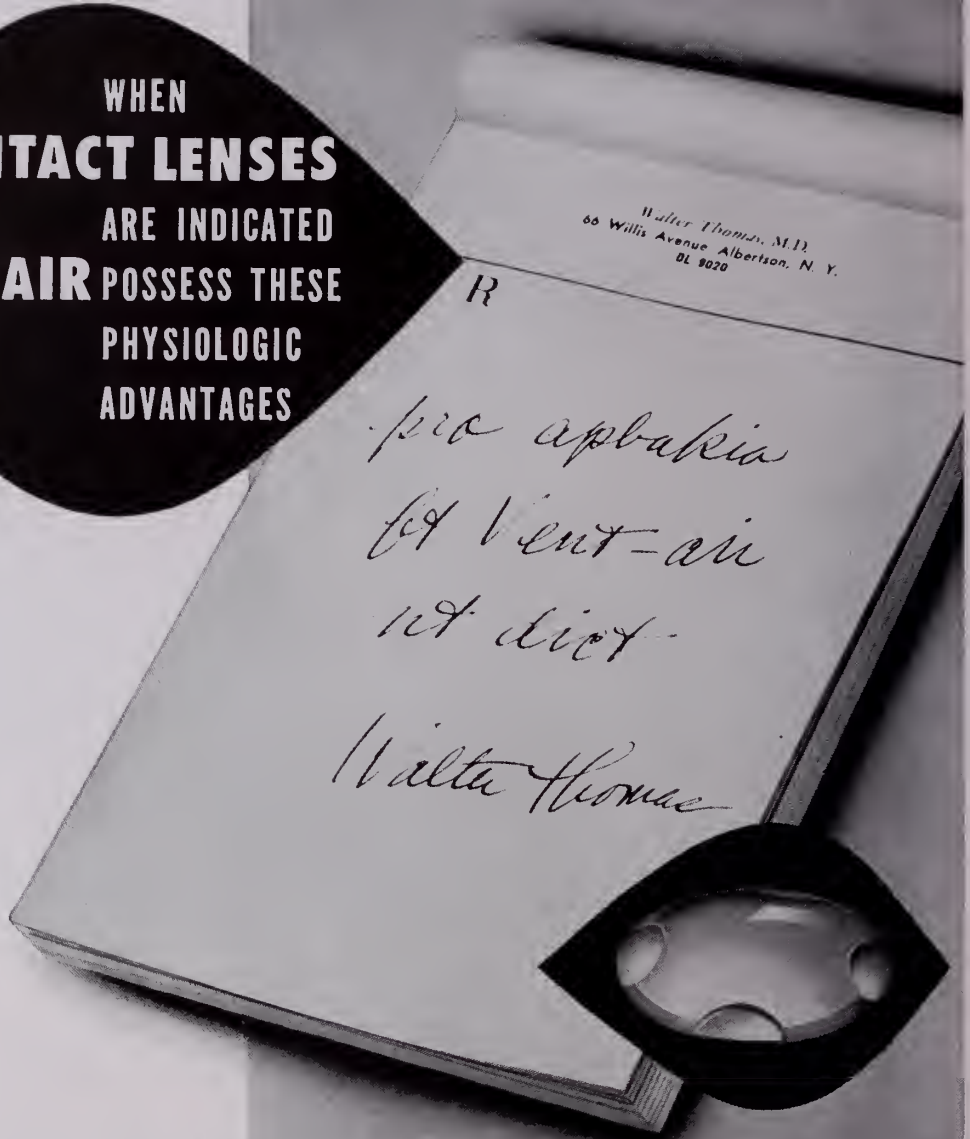
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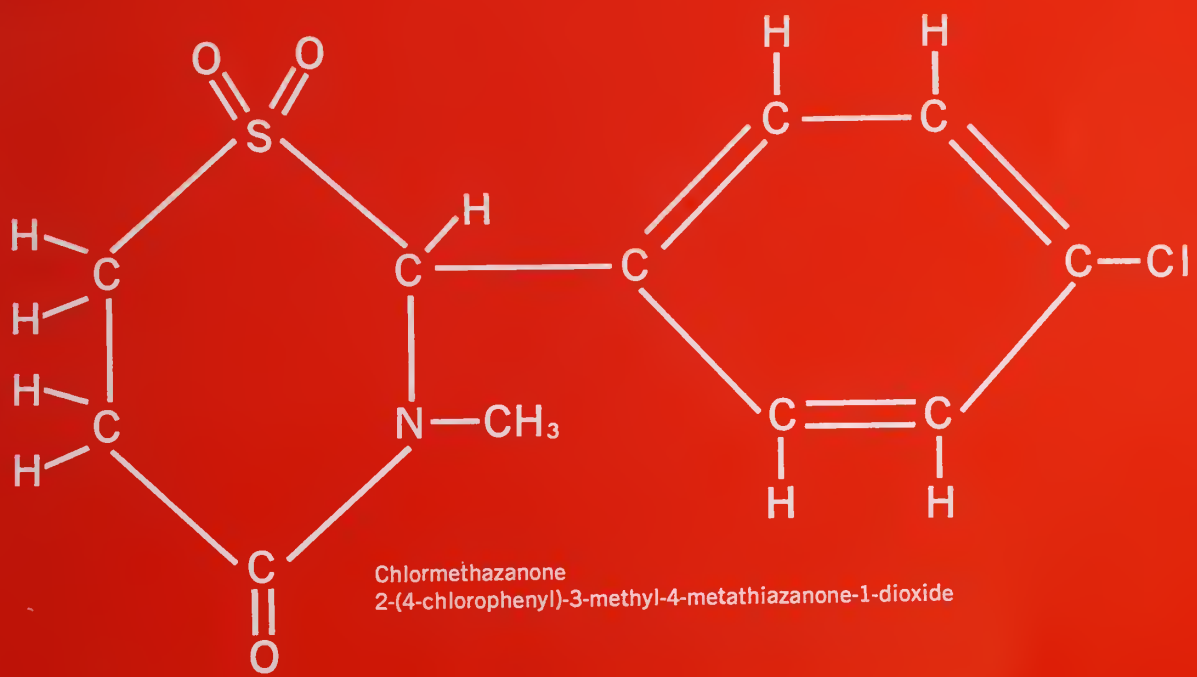
VENT-AIR CONTACT LENS LABORATORIES • NEW YORK, N. Y.

Winthrop Laboratories
introduces

Tancopal

BRAND OF CHLORMETHAZANONE

a completely new major chemical contribution to therapeutics



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

unrelated chemically to any other drug in current use

designed to be equally effective as both

a MUSCLE RELAXANT

a TRANQUILIZER

Trancopal

*the first true "TRANQUILAXANT"**

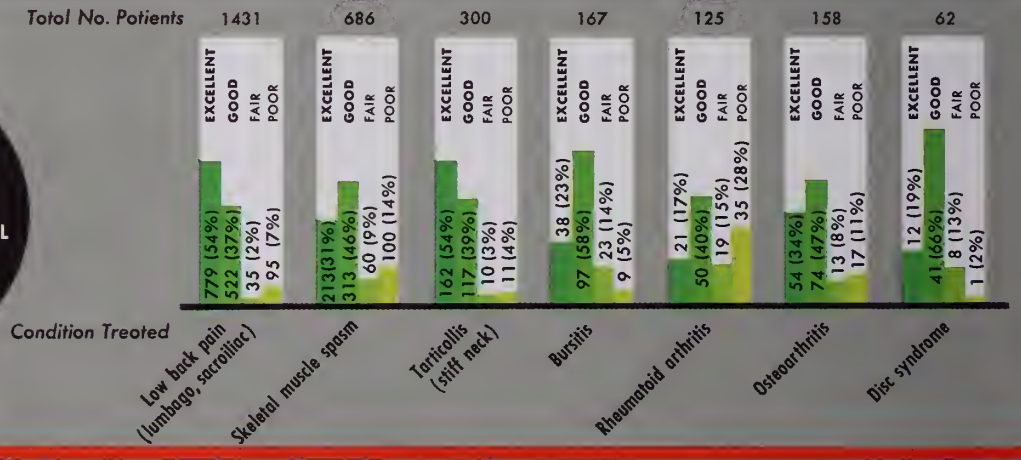
offering new freedom for your patients... from muscle spasm, from tension and anxiety, from side effects

* **tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

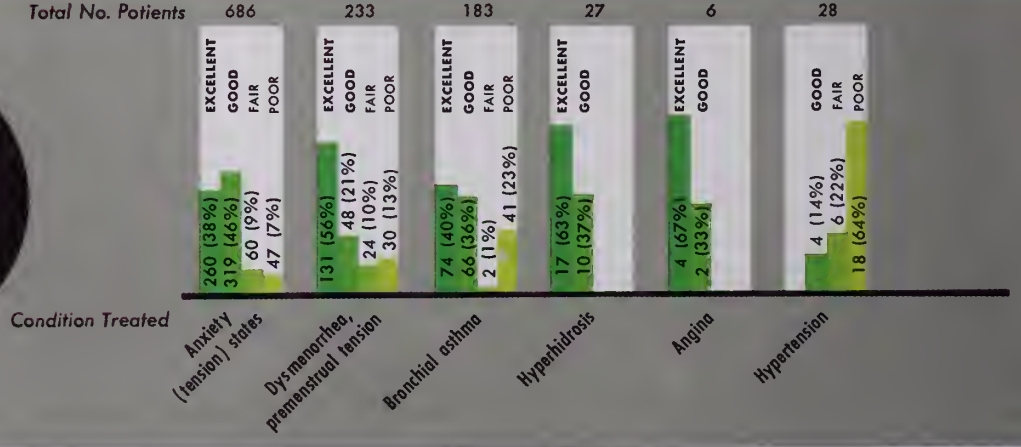
EXCEEDS OLDER DRUGS UP TO 4 TIMES IN PERCENTAGE OF CLINICAL EFFICACY (Lichtman)

The results of clinical studies of over 4000 patients by 105 physicians demonstrate that TRANCOPAL often is effective when other drugs have failed. From these studies it is clear that TRANCOPAL probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other chemotherapeutic agent in current use.

TRANCOPAL
IN MUSCULOSKELETAL DISORDERS



TRANCOPAL
IN PSYCHOGENIC DISORDERS



TRANCOPAL . . . the first true "tranquilaxant"

Both a muscle relaxant and a calmative agent.

In musculoskeletal disorders, 91 per cent effective.

In anxiety and tension states, 93 per cent effective.

Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.

No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.

Low toxicity. In animals, even less toxic than aspirin.

No gastric irritation. Can be taken before meals.

No clouding of consciousness, no euphoria or depression.

No perceptible soporific effect, even in high dosage.

CLINICAL RESULTS IN 4092 PATIENTS**



MUSCULOSKELETAL CONDITIONS
2929 Patients

+



PSYCHOGENIC CONDITIONS
1163 Patients

=



TOTAL 4092 Patients

MAJOR IMPROVEMENT
84%

**Caaperative Study, Department af Medical Research, Winthrap Labarataries.

Compare Trancopal with 3 widely used central relaxants

FOR ACTIVITY



Considering the usual human dose, Trancopal, the first true "tranquilaxant," is four to ten times as potent per milligram.

FOR SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.

FOR CLINICAL EFFECTIVENESS



A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of 40 patients received all four drugs in random rotation for several days. While each of the four drugs gave some relief, only the one providing the most effective relief was recorded.

INDICATIONS

Musculoskeletal
- Low back pain (lumbago)
- Neck pain (torticollis)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disc syndrome
- Fibrositis
- Joint disorders (ankle sprain, tennis elbow, etc.)
- Myositis
- Postoperative myalgias

Psychogenic
- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Emphysema
- Angina

Neurologic
- Muscle spasm in paralysis agitans, multiple sclerosis, hemiplegia, poliomyelitis

TRANCOPAL thoroughly evaluated clinically

"In the treatment of conditions associated with skeletal muscle spasm there was a high percentage of satisfactory results (excellent, good or fair) in 310 patients (94%) out of 331 treated. . . . In 120 patients with simple anxiety or tension states results were satisfactory in 114 (95%). Dosage of chlormethazanone in all cases was 100 mg. t.i.d. As well as relieving the anxiety or tension state, chlormethazanone also allowed these patients to resume their usual occupations."

(Lichtman)

"The effect of this preparation in these cases [skeletal muscle spasm] was excellent and prompt . . ."

Trancopal ". . . was effective in relieving the symptoms of anxiety . . . [with a] profile of pharmacologic actions similar to meprobamate . . ."

(Mullin and Epifano)

"We have just started using it [Trancopal] for relaxing spastic musculature and are very much encouraged."

(Baker)

Trancopal

the first true "TRANQUILAXANT"

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

Winthrop Laboratories • New York 18, N. Y.

• Baker, A. B.: Modern Med. 26:140, April 15, 1958. • Cohen, A. I.: In preparation. • Cooperative Study, Department of Medical Research, Winthrop Laboratories. • Gesler, R. M., and Coulston, F.: Toxicol. & Appl. Pharmacol. To be published. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:24A, Jan., 1958. • Gesler, R. M., and Surrey, A. R.: J. Pharmacol. & Exper. Therap. 122:517, April, 1958. • Lichtman, A. L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958. • Mullin, W. G., and Epifano, Leonard: To be published. • Surrey, A. R.; Webb, W. G., and Gesler, R. M.: J. Am. Chem. Soc. 80:3469, July 5, 1958.

Printed in U. S. A. 11-58 (3928A)

1 Ladeez and gentlemen:
learn all about new VITERRA PEDIATRIC,
a good supplement
in a great new package.



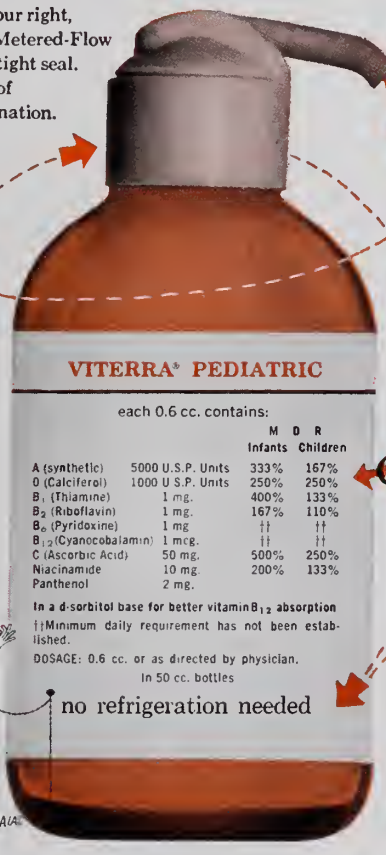
2 First,
see what happens when
you push the metered plunger.

3 Aha!
An exact 0.6 cc.
comes out this spout.
Never more, never less.



4 And notice –
no drip, no waste,
no sticky bottle.

5 On your right,
see the Metered-Flow
bottle's tight seal.
No risk of
contamination.



6 Let's take a minute
to admire the formula.





7 *That* means
no hot-weather
loss of potency.



8 Now for a farewell treat, a taste of delicious, orange-y VITERRA PEDIATRIC. How will you have it – in fruit juice? On cereal? Straight from the spoon?

VITERRA® PEDIATRIC



METERED-FLOW BOTTLE

ALLOW 30 SECONDS BETWEEN DISPENSINGS

Special note to doctors who took this tour:

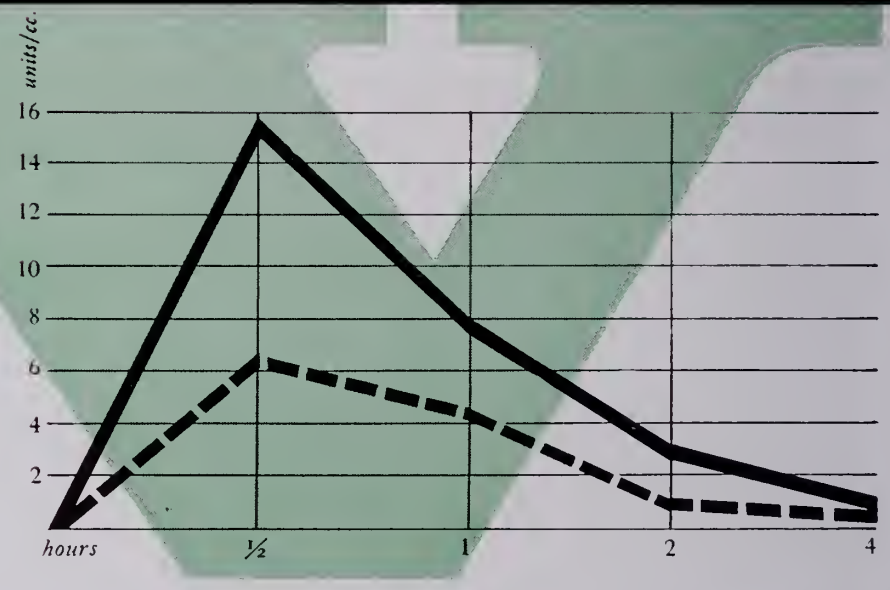
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The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before mealtime to 40 subjects involved in this study.

the higher
blood levels of
potassium
penicillin V

illin®-VK

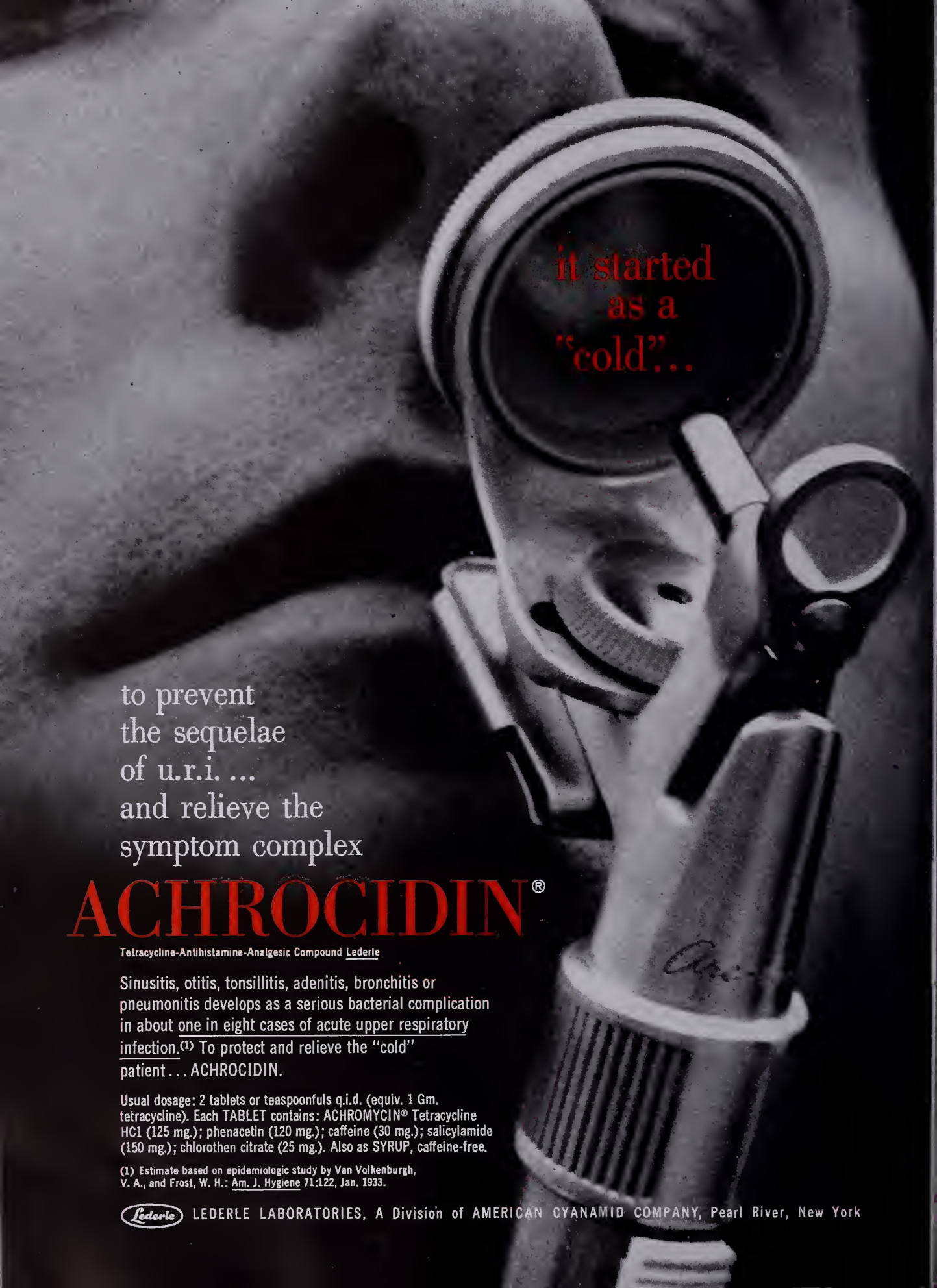
potassium penicillin V

IN FILMTABS,
COMPOCILLIN-VK comes in 125 mg. (200,000 units), bottles of 50 and 100, and in 250 mg. (400,000 units), bottles of 25 and 100.

FOR ORAL SOLUTION,
COMPOCILLIN-VK comes in dry granules for easy reconstitution with water. Cherry flavored, the granules are in 40-cc. and 80-cc. bottles. Each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

IN FILMTAB®/ IN ORAL SOLUTION

Abbott



to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE NOW SAYING ABOUT ATARAX®

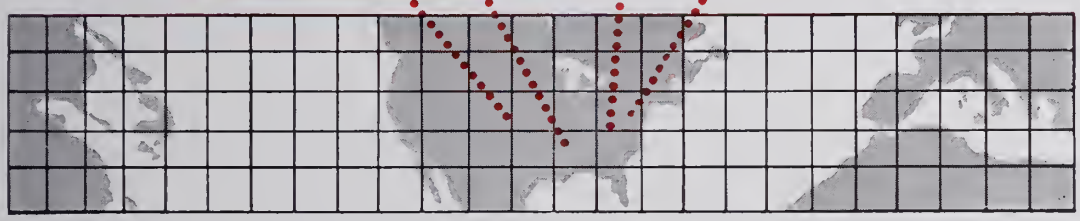
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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We will offer this investment opportunity to a few qualified individuals who are interested in a proved and profitable venture.

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PERTINENT PARAGRAPHS

The American Medical Association has announced another series of three regional medicolegal conferences in March and April as part of a continuing effort to create a better working relationship between doctors and lawyers. Dates and locations of the meetings are: at the District of Columbia Medical Society headquarters, Washington, March 20-21; at the Hotel Cleveland, Cleveland, April 4-5; and at the Hotel Utah, Salt Lake City, April 18-19.

The American College of Allergists Graduate Instructional Course and Annual Congress will be March 15-20, at the Mark Hopkins Hotel in San Francisco, California. For information contact: John D. Gillaspie, M.D., Treasurer, 2049 Broadway, Boulder, Colorado.

in peptic ulcer

REFRACTORY CASES RESPOND TO

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DARICON* *tablets*

OXYPHENCYCLIMINE HYDROCHLORIDE

POTENT ANTICHOLINERGIC ACTION

curbs secretion when excessive
normalizes motility when overactive

Activity appears to be restricted to the desired site of action.
Predictable therapeutic response in refractory cases.

Potency and Prolonged Duration of Action
10 mg. b.i.d. Average Dose · Supplied as:
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References: 1. Finkelstein, Murray: Journal of Pharmacology and Experimental Therapeutics, in press. 2. Winkelstein, Asher: Paper in preparation.
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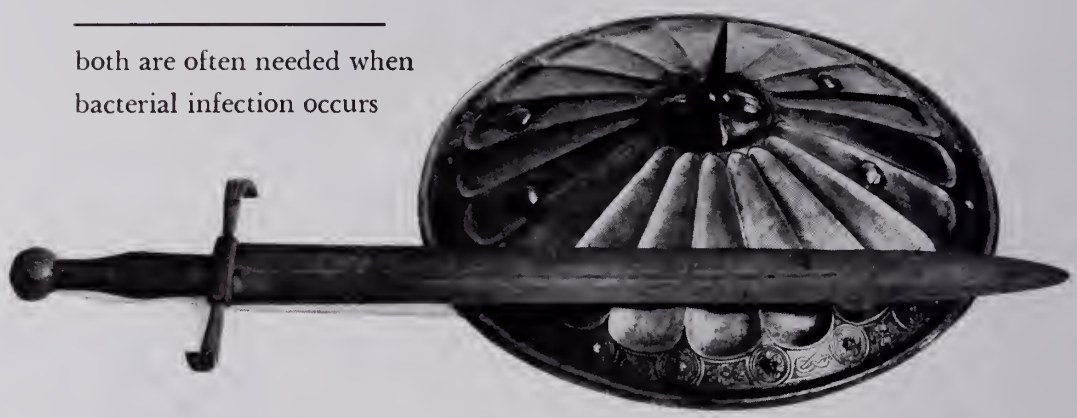
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▪ prompt, aggressive
antibiotic action
▪ a reliable defense against
monilial complications

both are often needed when
bacterial infection occurs



for a direct strike at infection
Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications
Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

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Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin)

Capsules *(250 mg./250,000 u.), bottles of 16 and 100.* Half-strength Capsules *(125 mg./125,000 u.), bottles of 16 and 100.*
Suspension *(125 mg./125,000 u. per 5 cc.) 60 cc. bottles.* Pediatric Drops *(100 mg./100,000 u. per cc.). 10 cc. dropper bottles.*

SQUIBB *Squibb Quality — the Priceless Ingredient*

'MYSTECLIN'®, 'SUMYCIN'®, AND 'MYCOSTATIN'® ARE SQUIBB TRADEMARKS

A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

consistently reliable and reproducible blood levels

minimal adverse reactions

With well-tolerated CYCLAMYCIN, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system—lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

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each coated tablet contains: **Phenaphen**	
Phenacetin (3 gr.)	194.0 mg.
Acetylsalicylic Acid (2½ gr.)	162.0 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine Sulfate	0.031 mg.
plus	
Prophenpyridamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10.0 mg.

PLAN TO ATTEND
March 11 and 12, 1959
5th Annual Symposium on Cardiovascular Diseases

ROOF GARDEN—BROWN HOTEL

LOUISVILLE, KENTUCKY

Guest Speakers

Wednesday, March 11

"The Master '2-Step' Test in the Diagnosis of Coronary Heart Disease
ARTHUR M. MASTER, M.D., Consultant Cardiologist Mount Sinai Hospital, New York, N. Y.

"Anginal Pain with Anatomic Normal Coronary Arteries"
DAVID SCHERF, M.D., Professor of Clinical Medicine, New York Medical College, New York, New York.

"Current Concepts of the Biology of Atherosclerosis"
E. COWLES ANDRUS, M.D., Associate Professor of Medicine, Johns Hopkins University, School of Medicine, Baltimore, Maryland.

"Rheumatic Fever and Rheumatic Heart Disease: A Twenty Year Perspective"
EDWARD F. BLAND, M.D., Associate Clinical Professor of Medicine, Harvard Medical School, Boston, Massachusetts.

"The Therapy of Hypertension"
S. W. HOOBLER, M.D., Associate Professor of Internal Medicine, Director of Hypertension Unit, University of Michigan Hospital, Ann Arbor, Michigan.

"Evaluation of Therapy of Hypertension"
WALTER M. KIRKENDALL, M.D., Director of Cardiovascular Research Laboratories, Associate Professor of Medicine, State University of Iowa, Iowa City, Iowa.

Thursday, March 12

"Management of Congestive Heart Failure"
WRIGHT ADAMS, M.D., Chairman, Department of Medicine, The University of Chicago, Chicago, Illinois.

"Homeostatic Mechanisms"
JAMES V. WARREN, M.D., Professor and Chairman, Department of Internal Medicine, University of Texas School of Medicine, Galveston, Texas.

"Uncommon Forms of Heart Disease"
J. D. MYERS, M.D., Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.

"Pericarditis"
JOHNSON MCGUIRE, M.D., Professor of Medicine, University of Cincinnati, College of Medicine, Cincinnati, Ohio.

"Surgery of the Aorta and Great Vessels"
DENTON A. COOLEY, M.D., Associate Professor of Surgery, Baylor University College of Medicine, Houston, Texas.

"Selection of Patients for Cardiac Surgery"
W. C. SEALY, M.D., Professor of Thoracic Surgery, Duke University School of Medicine, Durham, North Carolina.

DINNER SPEAKER
WEDNESDAY, MARCH 11
A. CARLTON ERNSTENE, M.D.
Cleveland, Ohio
President-Elect, American Heart Association
Subject
"The Clinical Spectrum of Coronary Heart Disease"

REGISTRATION $6.00 PER DAY

Eleven Credit Hours Allowed by American Academy of General Practice

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Lysine–Vitamins

BUILDS IRON RESERVES

BOOSTS APPETITE

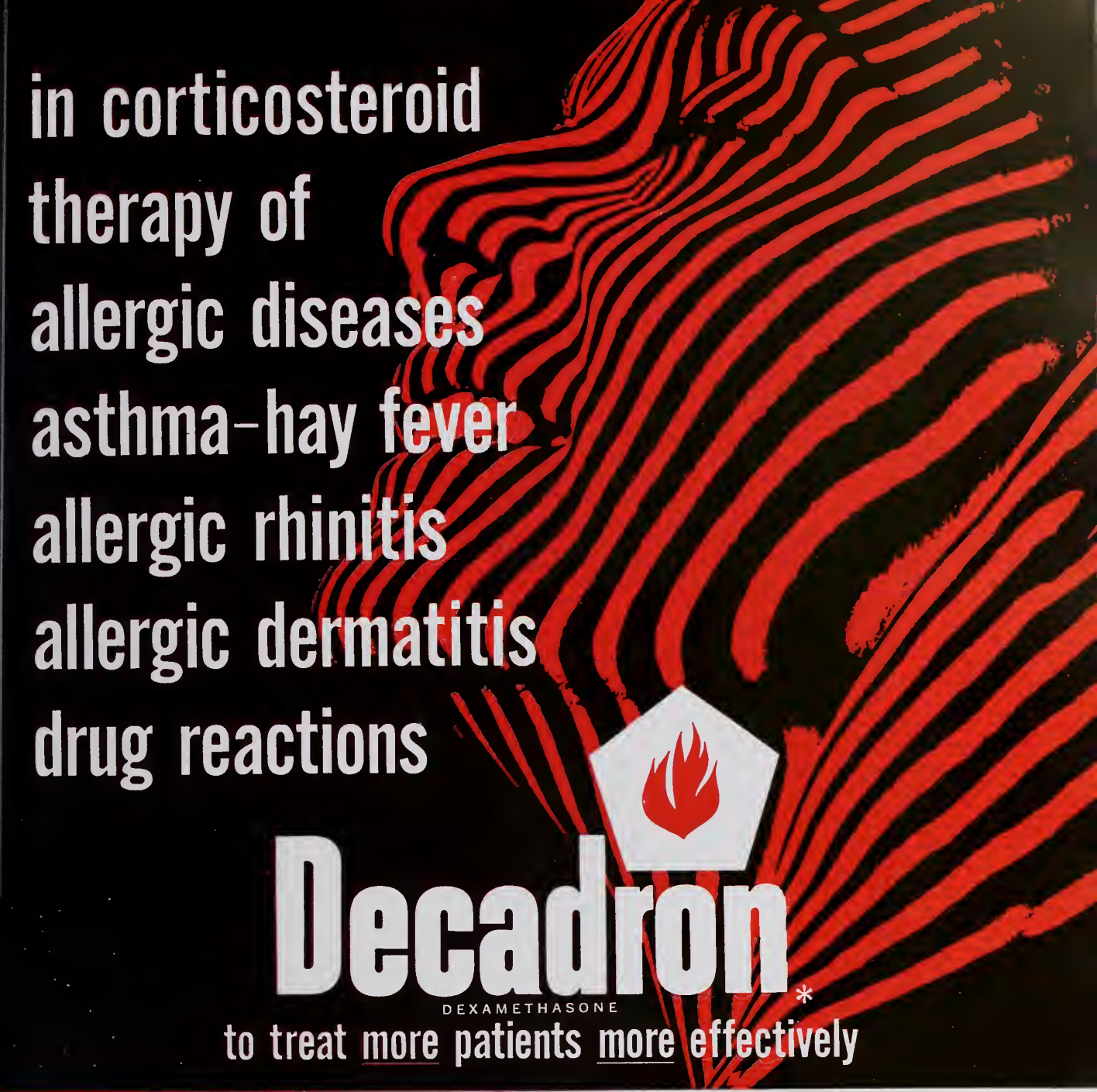
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Each daily teaspoonful dose (5 cc.) contains:

l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	0.75%

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a new order of magnitude in margin of safety

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Moreover, several investigators report that side effects induced by previous corticosteroid therapy such as gastric intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne often disappeared during therapy with **DECADRON.** †Analysis of clinical reports.

Dosage: One 0.75 mg. tablet of DECADRON will replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Detailed information on dosage and precautions is available to physicians on request.

Supplied: As 0.75 and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100.

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PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

Insulated brick and block structure, heated in winter by "Selectemp" Modulated Steam Heat with filtered air for maximum comfort and safety (each room having thermostatic even-heat control with its own circulating air unit).

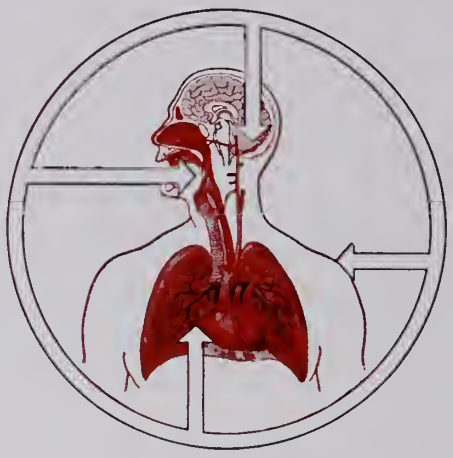
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Provides Triaminic for more complete and more effective relief from nasal and paranasal congestion because of systemic transport to *all* respiratory membranes—without drawbacks of topical therapy.†

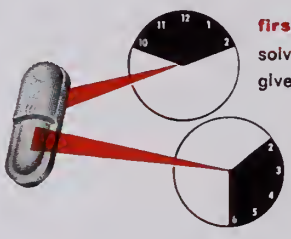
Provides well-tolerated APAP (N-acetyl-p-aminophenol) for prompt and effective analgesic and antipyretic action to make the patient more comfortable.

Provides Dormethan (brand of dextromethorphan HBr) for non-narcotic antitussive action on the cough reflex center in the medulla—as effective as codeine but without codeine's drawbacks.

Provides terpin hydrate, classic expectorant to thin inspissated mucus and help the patient clear the respiratory passages.

†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Special "timed release" design



first—the outer layer dissolves within minutes to give 3 to 4 hours of relief

then—the inner core releases its ingredients to sustain relief for 3 to 4 more hours

also available for those patients who prefer liquid medication: **Tussagesic suspension**

Each TUSSAGESIC tablet provides:

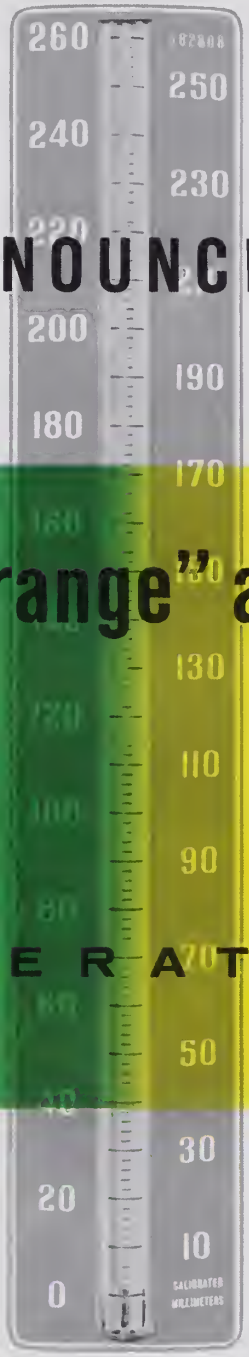
TRIAMINIC®	50 mg.
(phenylpropanolamine HCl	25 mg.
pheniramine maleate	12.5 mg.
pyrilamine maleate	12.5 mg.)
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	180 mg.
APAP (N-acetyl-p-aminophenol)	325 mg.

Dosage: One tablet in the morning, midafternoon and in the evening, if needed.

Tussagesic* *timed-release tablets*

Contains* **TRIAMINIC *to* STOP *running noses* *and open stuffed noses orally*

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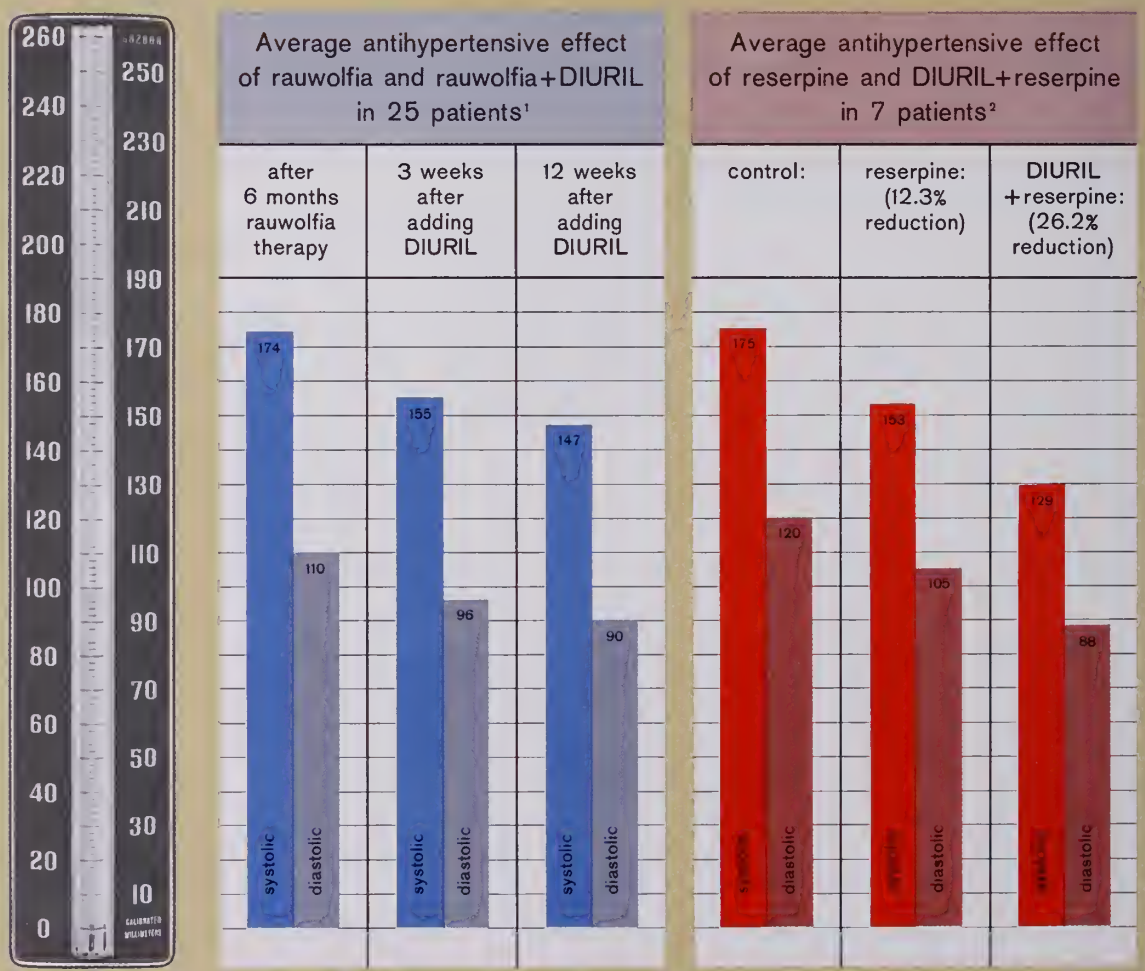
more hypertensives can be better controlled
with DIUPRES than with any other agent
...with greater simplicity and convenience

a logical alliance of two antihypertensives
you know and trust provides

increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.



DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

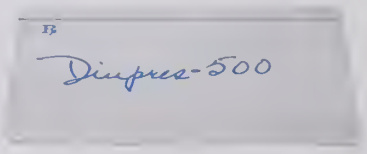
Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

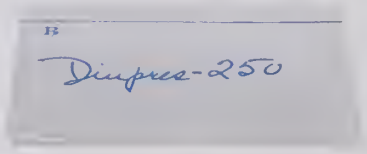
DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.



DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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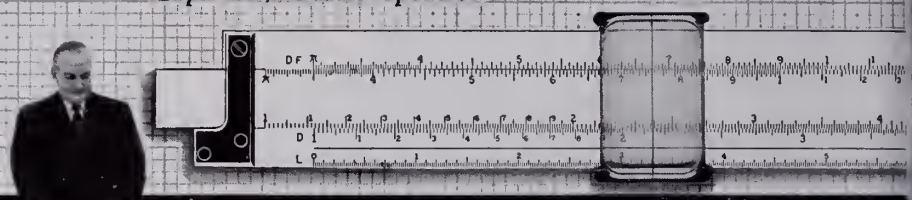
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** designed for superior control of common Gram-positive infections*

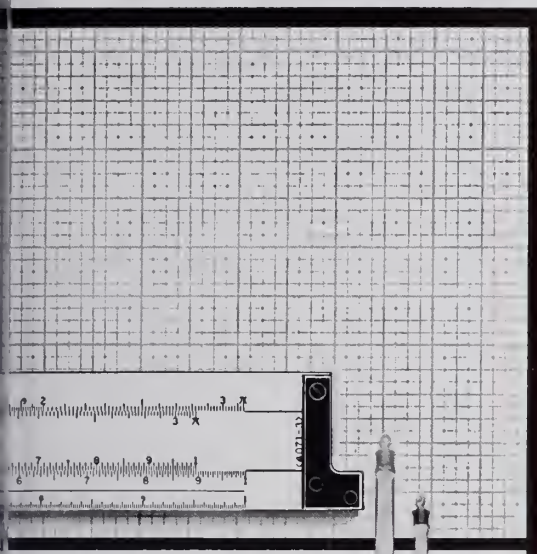




in the patient:

95% effective in published cases[1-8]

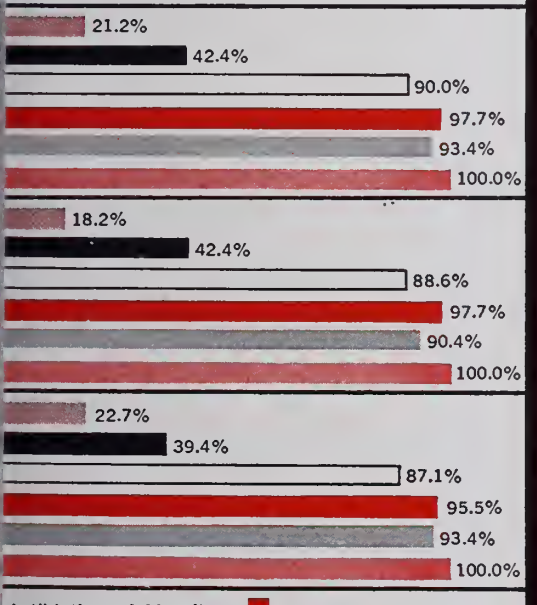
Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	448	80	30
Respiratory infections	**258**	208	31	19
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	191	38	1
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	19	3	6
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	30	8	4



ı the
ıboratory:

er 90% effective
;ainst resistant staph

MPARATIVE TESTS BY THREE METHODS
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130 STAPHYLOCOCCI[9]



rcentage of organisms inhibited by the range of
ıcentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity—freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules—250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension—1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Meilman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Oiansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Kareiitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goidin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

TAO dosage forms—
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TAO Pediatric Drops

For children—flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg. of TAO) and 10 drops (approx. 25 mg. of TAO). 10 cc. bottle.

TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action—in clinical emergencies.

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"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

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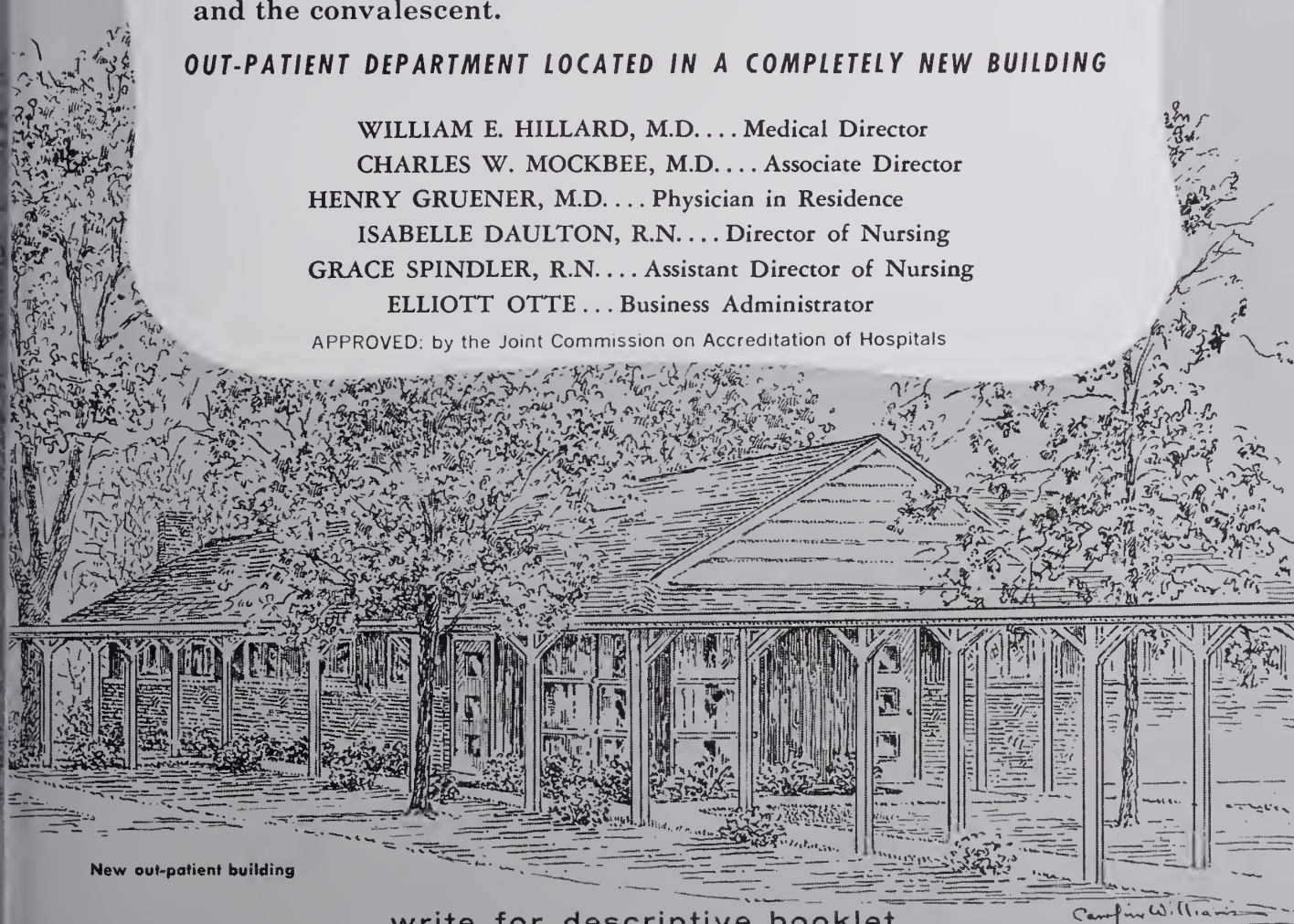
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effective against more than 30 common pathogens, even including resistant staphylococci.

[redacted] forms:

[redacted] Capsules, bottles of 16 and 100 capsules. Each ampule contains:

[redacted]mycin phosphate (tetracycline phosphate complex) equivalent to tetracycline hydro[redacted] 250 mg.
[redacted]mycin (as novobiocin sodium) 125 mg

[redacted] KM Flavored Granules, 60 cc [redacted] bottle. When sufficient water is added to fill the bottle, each teaspoonful (5 cc.) contains:

[redacted]mycin (tetracycline) equivalent to tetra[redacted] hydrochloride 125 mg.
[redacted]mycin (as novobiocin calcium) 62.5 mg
[redacted] metaphosphate 100 mg.

[redacted]

[redacted] Capsules: Usual adult dosage is 1 or 2 capsules 3 or 4 times a day.

[redacted] KM Granules:
For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 30 lbs. of body weight per day, administered in 3 or 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.



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BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic . . . stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride . . 8.33 mg.
Pyridoxine hydrochloride . . . 16.67 mg.

Dosage:

under 6 months . . . . 0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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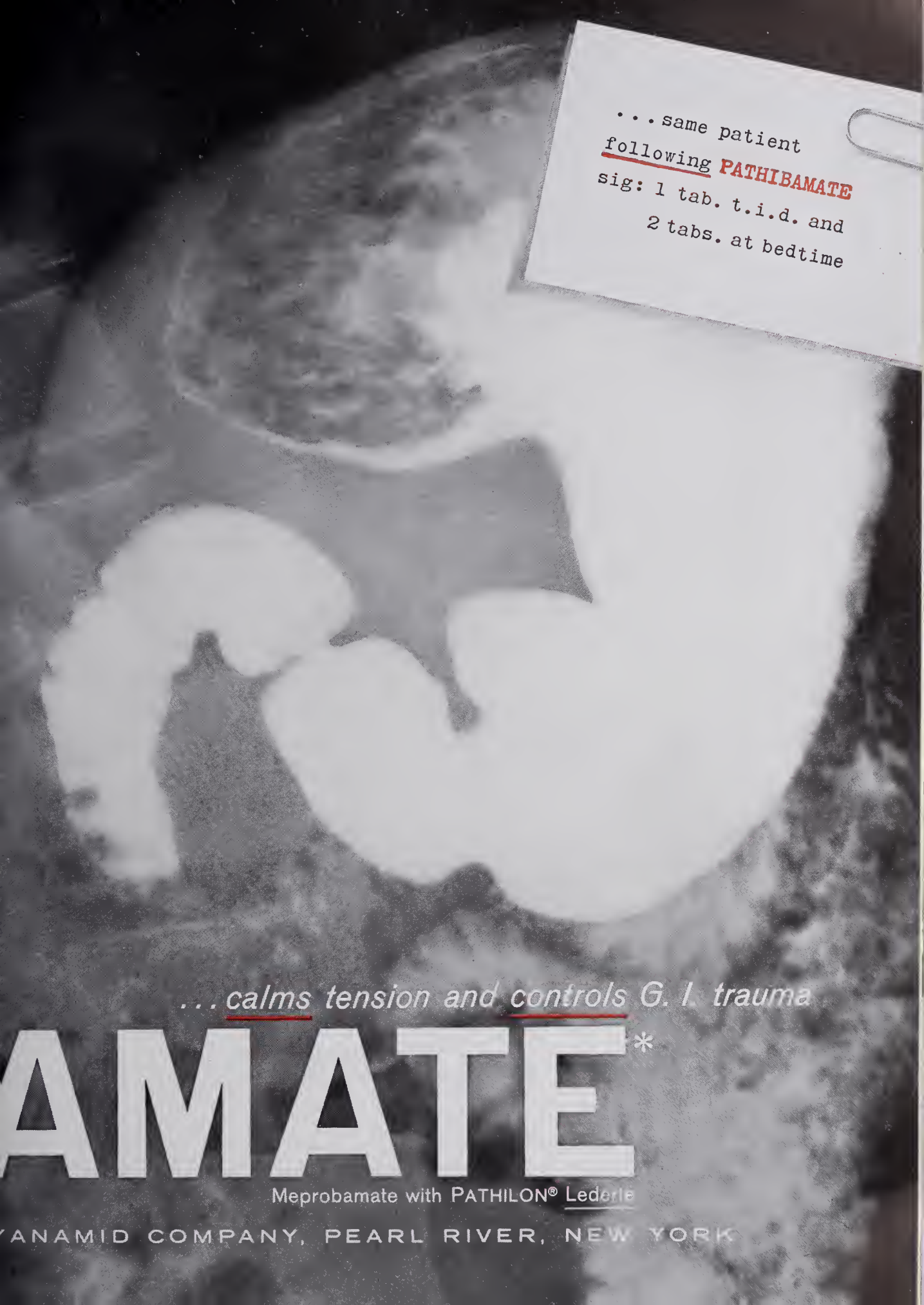
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References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. *257*:278 (Aug.) 1957.

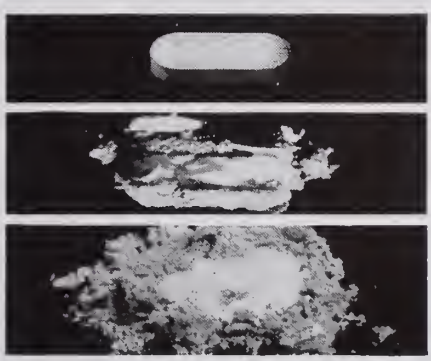
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"ankle-itis"
there's pain and
inflammation here...
it could be mild
or severe, acute or
chronic, primary or
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References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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What differentiates "renal diabetes" (renal glycosuria) from diabetes mellitus?

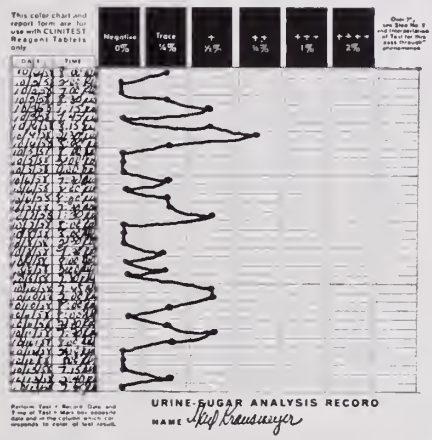
Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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*GP *16*:121 (August) 1957.



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THE JOURNAL

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FEB 1 1

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Coccygodnia

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VOLUME 57 • NUMBER 2 • FEBRUARY 1959

EFFECTIVE AGAINST MOST STRAINS OF STAPHYLOCOCCI

CHLOROMYCETIN®

COMBATS MOST CLINICALLY IMPORTANT PATHOGENS

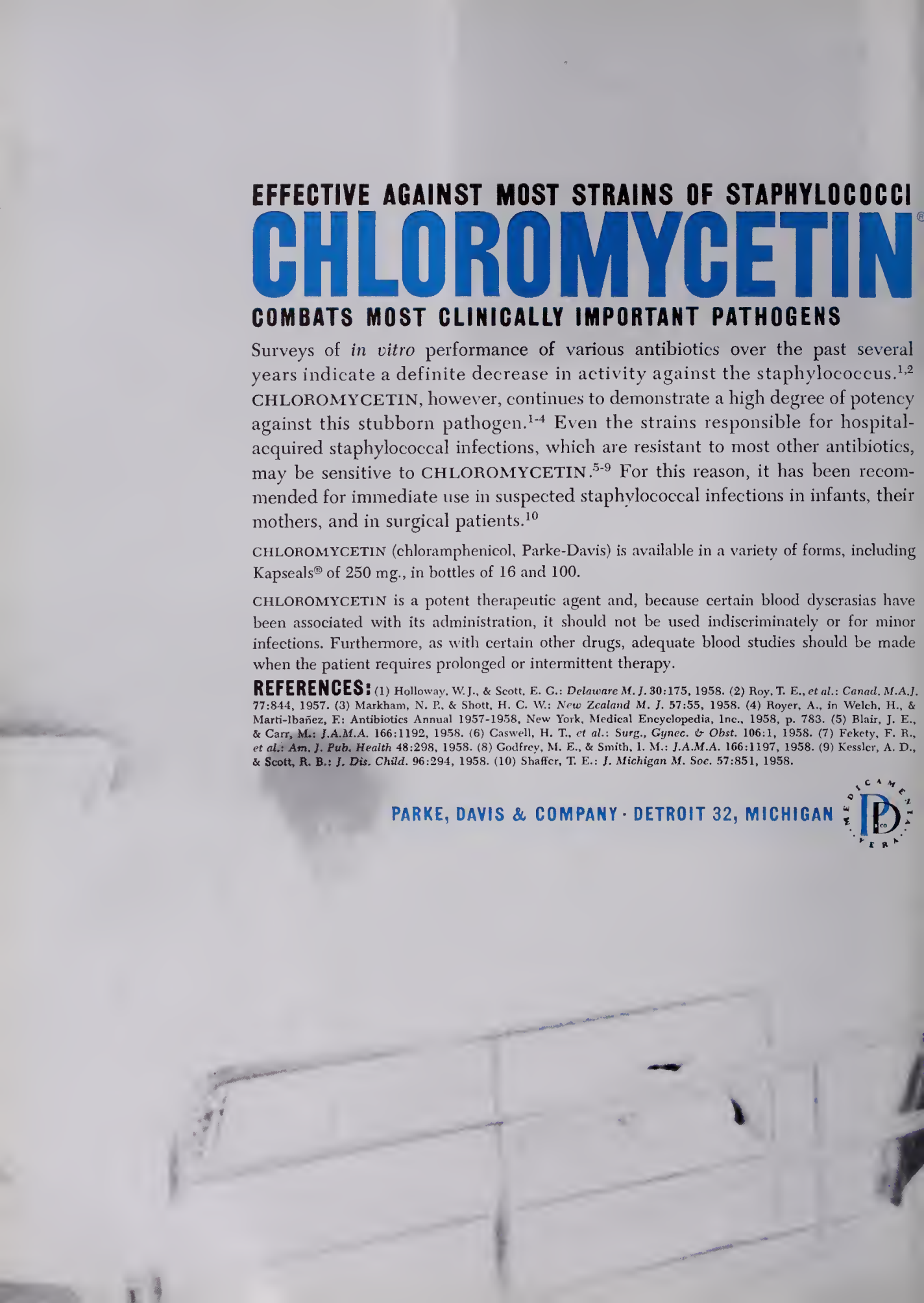
Surveys of *in vitro* performance of various antibiotics over the past several years indicate a definite decrease in activity against the staphylococcus.[1,2] CHLOROMYCETIN, however, continues to demonstrate a high degree of potency against this stubborn pathogen.[1-4] Even the strains responsible for hospital-acquired staphylococcal infections, which are resistant to most other antibiotics, may be sensitive to CHLOROMYCETIN.[5-9] For this reason, it has been recommended for immediate use in suspected staphylococcal infections in infants, their mothers, and in surgical patients.[10]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

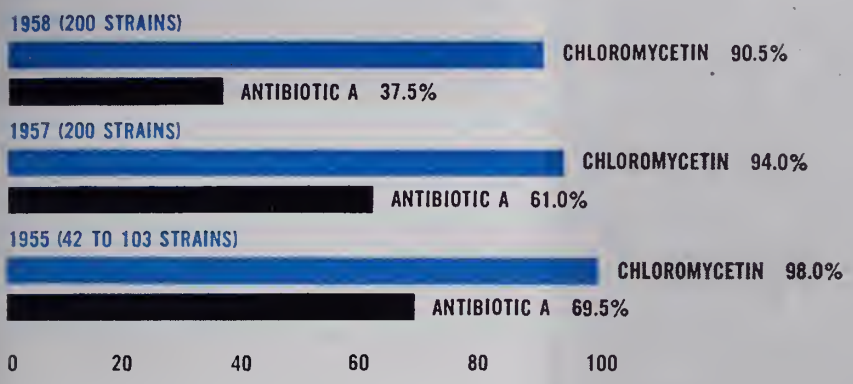
CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (2) Roy, T. E., *et al.*: *Canad. M.A.J.* 77:844, 1957. (3) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (4) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (5) Blair, J. E., & Carr, M.: *J.A.M.A.* 166:1192, 1958. (6) Caswell, H. T., *et al.*: *Surg., Gynec. & Obst.* 106:1, 1958. (7) Fekety, F. R., *et al.*: *Am. J. Pub. Health* 48:298, 1958. (8) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* 166:1197, 1958. (9) Kessler, A. D., & Scott, R. B.: *J. Dis. Child.* 96:294, 1958. (10) Shaffer, T. E.: *J. Michigan M. Soc.* 57:851, 1958.

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IN VITRO SENSITIVITY OF PATHOGENIC STAPHYLOCOCCI TO CHLOROMYCETIN AND TO ANOTHER WIDELY USED BROAD-SPECTRUM ANTIBIOTIC FOR 1958, 1957, and 1955*



*Adapted from Holloway and Scott.[1] In this study CHLOROMYCETIN and Antibiotic A were used in identical strengths of 5 mcg.

71359



The JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

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Dr. Lucas
Vice President-Central District

President's Page*

FOR the past several years we have been hearing from many sources "The doctors are always saying 'no' to everything. They never have a plan to help the people."

At the recent December AMA session in Minneapolis a little publicized, important event transpired. Our delegates approved a committee report voting a positive approach to one of the three great problems facing the health of our people, the care of our Senior Citizens.

It was voted that the doctors promote and enourage making it possible for our Senior Citizens to be covered by health and hospitalization insurance, even to the extent of reduced rates for doctors' fees to this increasingly important group. This is to make it actuarily sound. The Blue Shield groups and the Blue Cross insurance plan and many of the other hospitalization plans have indicated great interest and willingness to prepare rates for insurance of our over 65 and 70 people.

Now our AMA delegates speaking for all of us, have taken a positive stand, saying, "We, doctors are ready to go more than half-way."

That leaves the one great medical expense, the one which today costs double the doctors bill, the hospitalization costs. The doctors' action needs implementation from the grass roots, the county societies, on up. This may stimulate the American Hospital Association to come forth with equal willingness to make concessions to shoulder their part of the load.

It's time—that time is now. Let our county societies speak out. There is no "drouth at the grass roots" of private American medicine.

On the same subject, mention should be made of a valuable possible source of new nursing homes. With the new superhighway systems there will be many fine motels which will find their business dislocated. These motels are often air conditioned. They have good, economical heating systems. They are accessible. They have adequate grounds. In short, they are well suited to be nursing homes.

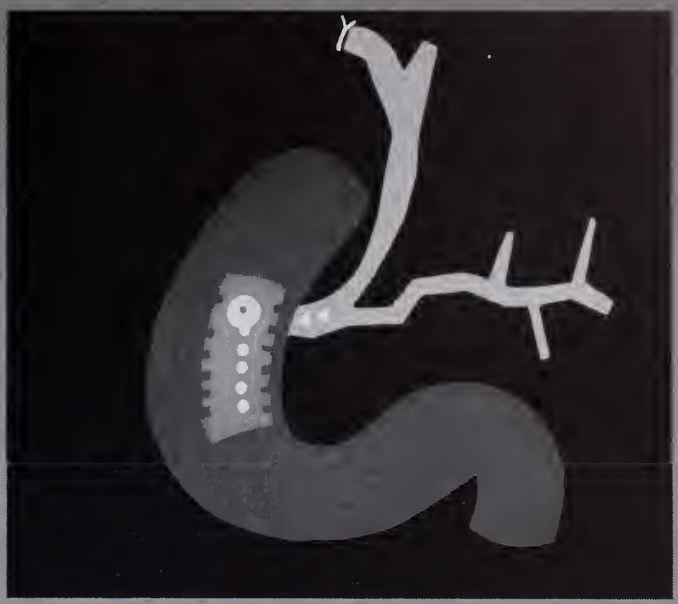
In Louisville one such motel has been converted. It is particularly well liked by the residents of this new type nursing home. Here is another chance for positive approach.

Let the doctors in each community bring this to the attention of their Chamber of Commerce. It is to the interest of the Chamber to see that all community facilities are well used and busy.

Marvin A. Lucas, M.D.
Vice President—Central District

This is the first of a series of three guest articles to be written by the KSMA vice presidents at the invitation of Robert W. Robertson, M.D., president.

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Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

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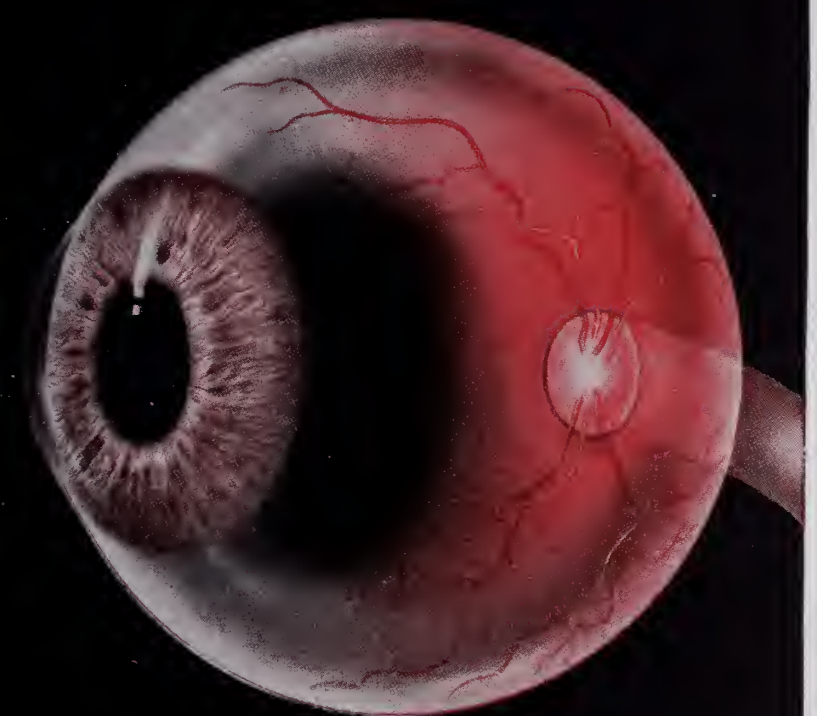
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Reinhardt, D. J.:
Delaware State Med. J. **30**:1, January 1958.

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Bunn, W. H., Jr.:
Ohio State Med. J. **54**:1168, September 1958.

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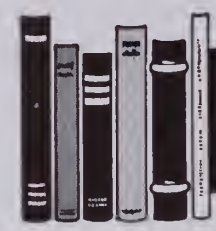
Herrmann, G. R., Hejtmancik, M. R., Graham, R. N. and Marburger, R. C.:
Texas State J. Med. **54**:639, September 1958.

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IN THE BOOKS



Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

BONE TUMORS, by Louis Lichtenstein, M.D., published by the C. V. Mosby Company, St. Louis.

CLINICAL OBSTETRICS AND GYNECOLOGY: Volume 1, Number 4, Symposium on Operative Obstetrics and Symposium on Genital Cancer, published by Paul B. Hoeber, Inc., New York.

THE SEDIMENTATION RATE OF HUMAN ERYTHROCYTES: by Frank Wright, M.D., published by Vantage Press, New York.

HOW TO LIVE WITH DIABETES: by Henry Dolger, M.D., and Bernard Seeman; published by W. W. Norton and Co., Inc., 1958; 192 pages; price, $3.50.

A physician and a professional science writer cooperated in writing this book. In writing for patients they use terms such as "who gets diabetes" instead of "incidence." A similar simplifying job is done on the technical jargon of more complex medical ideas such as the hereditary, predisposing and metabolic problems in diabetes.

They present a review of the history of diabetes as the exciting story of discovery that it is. The bulk of the book deals with routine management, and the special problems of childhood, adolescence and pregnancy. The attitude toward diet is quite liberal, and the enthusiasm expressed for oral hypoglycemic drugs is extreme.

Many pages are devoted to Orinase (book was presented by Upjohn), and the authors herald this drug as the presage of "a revolution in treatment virtually as great as that brought about by the discovery of insulin."

Throughout the book the writers are realistic and treat diabetes as a true handicap. They discuss the various complications of diabetes with a particularly good section on insulin reactions. They explain to the patient that despite all his efforts to achieve good control he may still get some of the serious neurologic and vascular complications.

Hope for the future is given the patient by way of an intriguing comparison. Certainly the various hyperglycemic states which we label as "diabetes mellitus" will be further resolved into various biochemical entities. Oral hypoglycemic drugs and other advances in endocrinology have partially accomplished this already. The authors compare the diagnosis of "diabetes mellitus" with the diagnosis of "The Fever" as it was made a century ago. Just as treatment of fever is directed at the underlying cause, the future will depend upon definitive treatment for the underlying biochemical lesions which cause the symptom called diabetes mellitus.

Stuart Urbach, M.D.

THE CARE OF THE GERIATRIC PATIENT: Edited by E. V. Cowdry, Ph.D., Sc.D. (Honorary); published by C. V. Mosby Company, St. Louis, 1958; 438 Pages, 18 Tables; Price $8.00.

The inspiration for Dr. Cowdry's labors was born in the prolongation of life in the United States by eighteen years within the past fifty years. The material was gathered by enlarging the scope of a geriatrics symposium by the Los Angeles County Medical Association in 1955.

This book was organized under nineteen headings: the relationship between physician and geriatric patient, psychological management, medical aspects, surgical aspects, mental aspects, anesthesia, drugs, nutritional requirements, dental care, genetic factors, nursing, hospitalization, nursing homes—proprietary and non-profit, home care, rehabilitation, training, organizations and services, and world-wide study. Each section was written by an author who has had a rich background in his own particular field.

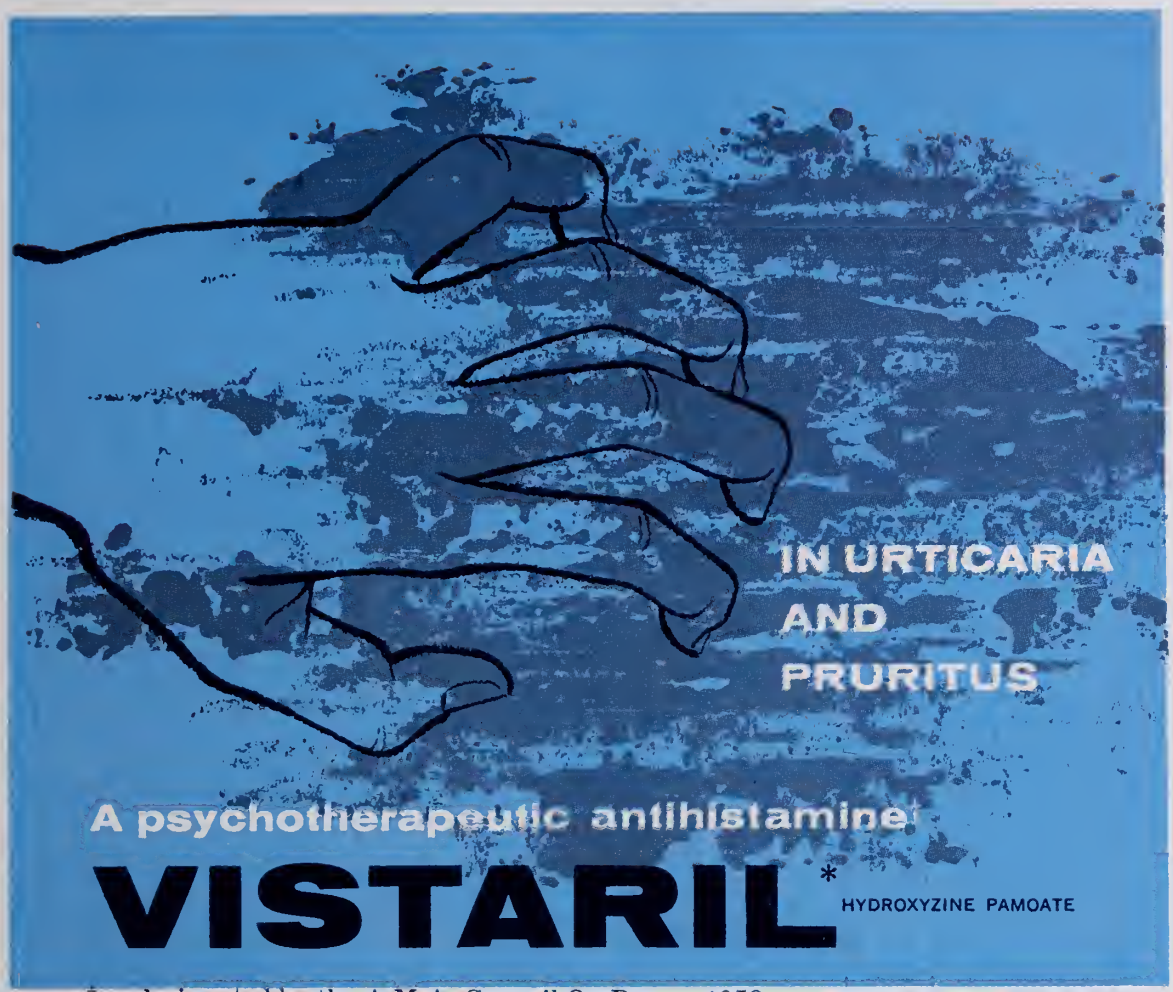
The forte of this book was the discussion of the common misconceptions of aging, the great responsibility of the gerontologists in determining the way of life for a large segment of the population in the United States, and a plea for more research in geriatric problems. The tables were concise, and time consuming statistics were held to a minimum. Rather than finding a professional treatise, the reader was pleased to find a pleasant office chat of great practical value.

The reviewer would like to mix with commendation of this book one small note of criticism. More than several of the concepts and conclusions in the book lacked solid scientific proof. Not only deductions of shaded clarity, but highly controversial issues were treated with misleading brevity.

There was much of importance in this book for students of geriatrics. It is recommended to places where medical and surgical residents train. It should be on the agenda of every general practitioner. This book could stimulate much needed study of geriatric problems.

Jerry M. Shaw, M.D.

(Continued on Page 140)



† as designated by the A.M.A. Council On Drugs, 1958

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References: 1. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 2. Eisenberg, B. C., Clinical Medicine *5*:897-904 (July) 1958. 3. Robinson, H. M., et al.: J.A.M.A. *161*:604-606 (June 16) 1958. 4. Robinson, H. H., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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IN THE BOOKS

(Continued from Page 138)

CALLANDERS SURGICAL ANATOMY; by Barry J. Anson, M. A., Ph.D., and Walter G. Maddock, M.S., M.D., fourth edition, published by W. B. Saunders and Company, Philadelphia and London, 1958; 1157 pages; 1047 illustrations; price, $21.

This fine volume following the preceding three editions is written in the same format as the others were.

There are 1047 excellent illustrations. Many of these are additions to those in the third edition. Some which appeared in that edition have been omitted. The illustrations have adequate captions and descriptions. All told, this serves to make a more modern book.

As an anatomy book, the illustrations appear in black and white and consequently, are not quite so good as the surgical atlas in regard to multi-colored illustrations depicting relationships.

However, in contradistinction to the ordinary atlas of anatomy or the usual anatomical text book, there are comments by the authors on the surgical implications in each region as it is described and illustrated. Along near the end of each subject, some of the surgical techniques for that region are described and illustrated and in general, are quite good.

Again, the book can not possibly cover such a wide field as the entire human body and still be authoratative and ultimate in every respect. Consequently, only a single type of procedure for a given subject is usually illustrated. As is commonly known, there often are more than one or two procedures which are very satisfactory to accomplish a given end by surgery.

In my mind, the implications of this book as a surgical anatomy are quite excellent with organization being good and details being in most instances adequate for surgical refreshment or for the novice surgeon to cover a given area prior to performing surgery.

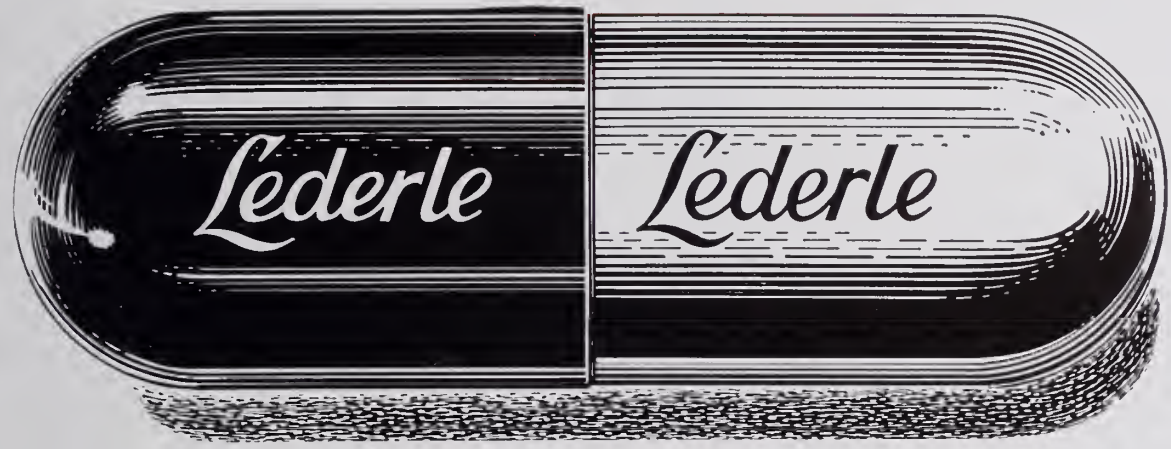
In consideration of the more commonly performed operations that are illustrated and described, I am reminded of the Reader's Digest in the lay magazine field in which the cream is condensed and many other important things are often left unsaid.

The main drawback to the book lies in that constant fault with most tests; that is, by the time of their printing, part of them invariably is out of date. Fortunately, the authors have avoided some difficulties in this regard by not touching too heavily on the controversial surgical procedures such as those regarding surgery of the pancreas for chronic pancreatitis.

In summary, the book is excellent as a study book for embryo surgeons and as a reference source for a concise refresher for that area in which the trained or mature surgeon only occasionally operates.

Bourbon E. Canfield, M.D.

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PUBLIC HEALTH PAGE

Leptospirosis

RUSSELL E. TEAGUE, M.D.
Commissioner of Health
Commonwealth of Kentucky

For many years, the leptospiroses were considered rare diseases, but it is now well-established that they occur in humans and animals throughout the world and that they constitute a major problem in certain domestic animals. Several cases have recently been diagnosed in Kentucky by the State Department of Health laboratory in Louisville. An adequate knowledge of the distribution of leptospires in potential wild and domestic animal carriers and the factors that influence the roll of these carriers in the transmission of leptospiral infections to humans is of particular importance.

The leptospiral infections are zoonoses, that is, transmissable from animal to animal and from animals to humans. Infection in humans is accidental, and with rare exception, it represents a dead end in the chain of transmission. Although rodents and certain domestic animals are considered to be the primary animal carriers, recent investigation has revealed the variety of hitherto unrecognized wild animal hosts and current studies are detecting additional sylvatic leptospiral carriers.

In the kidneys of these host animals the leptospiroses display an affinity for the renal cortex and may be found nesting in the lumina of the convoluted tubules. They may be shed in the urine for long periods. Each leptospiral serotype is believed usually to have a primary animal host for which it is particularly adapted. However, these serotypes will infect other animals as well. Furthermore, a single animal specie may become infected with a number of different serotypes or even harbor two types at once.

Although the primary problem in the United States appears to be with L. icterohaemorrhagiae, L. canicola, and L. pomona, seven other serotypes have been isolated and serologic findings suggest the presence of at least two others.

Of primary importance in the transmission of leptospiral infection to humans are the animal carriers. They become urinary shedders of leptospires. After acute, mild, or, more frequently, inapparent infection, the organisms become established in the kidneys and are eliminated in the urine. Infections of humans and animals result from direct or indirect contact with the infected human or the shedders. For example, direct contact may occur when individuals care for sick animals or handle the tissues of infected animals in abattoirs. Indirect contact occurs when water or wet soil is contaminated and individuals are overly exposed while working or swimming, or otherwise come in contact with the contaminated environment.

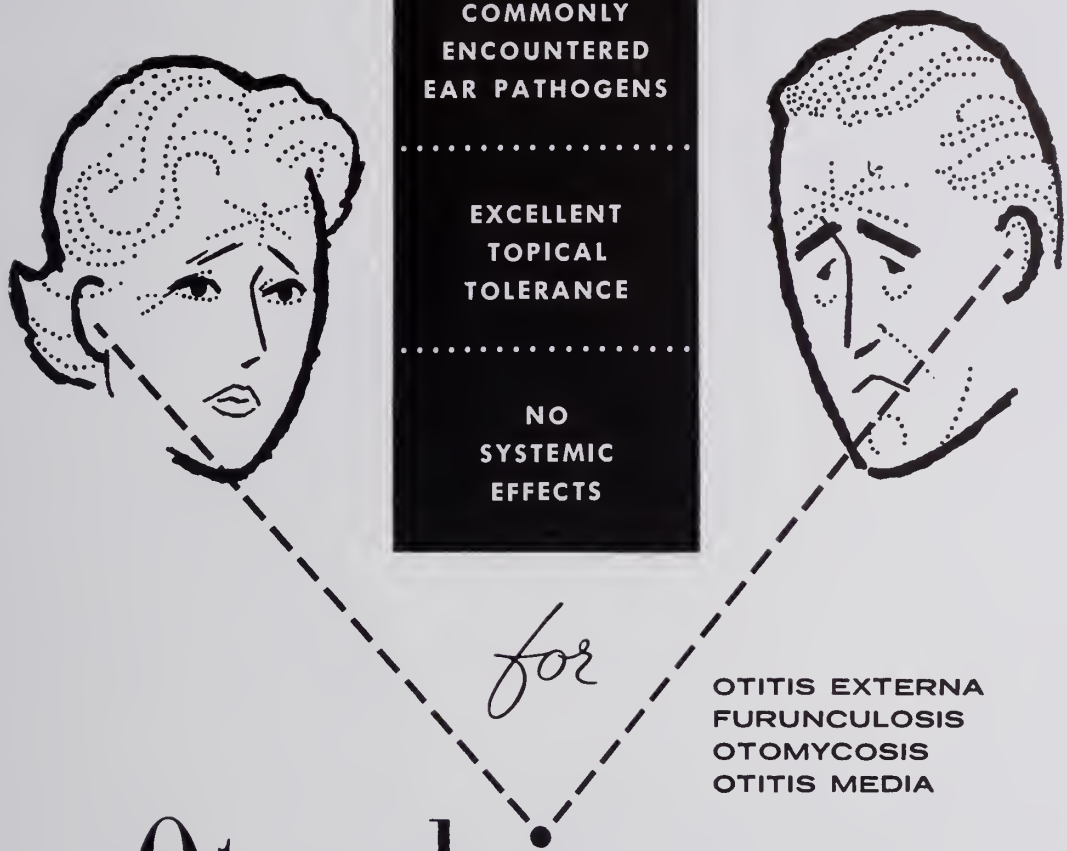
Arthropod vectors have not been incriminated as yet in the transmission of leptospirosis in nature. The portals of entry of infection are usually the nasal, oral, and conjunctival mucous membranes, and abraded skin. There is considerable doubt that leptospires penetrate the intact skin and it is unlikely that the digestive tract is an important portal of entry since the pH of the stomach is usually such that the organism may be destroyed quickly.

Environments that favor the survival and spread of leptospires are wet soil, stagnant water, or slow-moving streams that are neutral or slightly alkaline when temperatures are 22° C or above. Under such conditions leptospires may survive for several weeks.

The clinical features of human leptospirosis vary considerably, cause illnesses as severe as fulminant hepatitis and as mild as influenza. The manifestations that suggest the diagnosis of Weil's disease are severe fever, prostration, icterus, renal decompensation, hemorrhagic phenomena and vascular collapse. Milder forms of leptospirosis are more difficult to recognize, but leptospiral etiology should be considered in any febril patient when severe headache, vomiting, myalgia, conjunctival injection, proteinuria and neutrophilia are noted. Leptospirosis is to be suspected, further, whenever there is an extra amount of exposure to those environmental conditions that favor infection.

In summary, leptospiral infections are known to occur in wild and domestic animals throughout the world. All leptospires known to infect animals are potentially pathogenic for humans. While some serotypes appear to exhibit a certain host preference, all of the more common types have been found to infect more than one animal specie.

Of primary importance is the chain of transmission are the animal carriers of leptospires. After acute, mild, or even inapparent infections, the organisms localize in the kidney and are shed in the urine for varying periods. These carriers serve as foci of infections for other animals and man.



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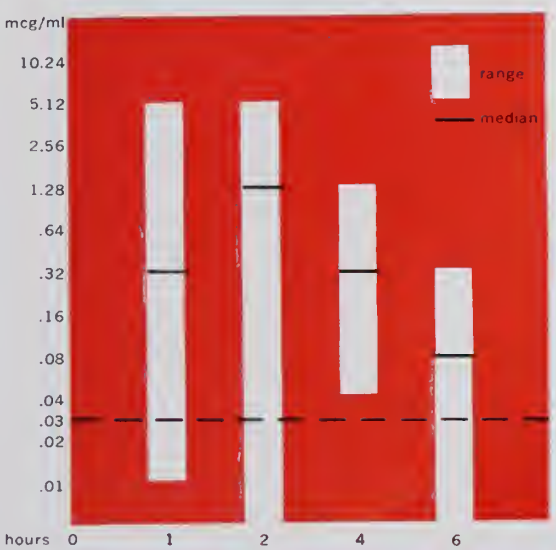
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From the Files of the

Committee for the Study of Maternal Mortality

Case #14: The patient was a white married 18-year-old gravida 2, para 1, who delivered spontaneously at home with her mother as the only attendant two days before she was admitted to the hospital. It is of interest that the first child was similarly delivered at home with only her mother in attendance, sixteen months before.

She consulted her physician when she was in her eighth month of pregnancy and was seen only twice. Her reason for these visits to the doctor was extreme weakness plus an ulcerated, sore mouth. She was treated with some vitamins at this time, a mouth wash and penicillin. The patient was so lethargic it was necessary for her to live with her mother. She was unable to do her house work. On the subsequent visit to her family doctor no examination was made nor was any medication given.

She delivered spontaneously at home; there was no additional examination connected with the delivery nor was the fate of the infant given, only the mother's statement that there was no bleeding at delivery. Two days postpartum her family physician was called; the patient developed weakness and was running a temperature, the degree wasn't stated. He again gave her penicillin, plus oral sulfa and admitted her to the hospital.

On admission to the hospital at 12:46 P.M. May 30, 1957 the examining physician was impressed with her white color and noted that she was slightly puffy, but not truly edematous. Her sclera were extremly blue, her eyes rolled and she didn't seem to be in contact with her surroundings although she cried out in pain. There was some froth present in the corner of her mouth. Her pulse was dicotic but of fair volume, the rate 120 per minute. The blood pressure was recorded as 100/0 and her temperature 99°. Her chest seemed full of moist rales. Further examination was non-contributory except for a deep unsutured perineal laceration: however, it did not appear infected.

Laboratory findings: The hematocrit was 6.8% with less than 2 grams of hemaglobin. The RBC was 540,000. The WBC was 9,700, the differential revealed 56 polys, 4 stabs, 39 lymphocytes and 1 monocyte. The cells were noted to appear hyperchromic, moderate anisocytosis, slight oliogcytosis, moderate polyomatophilia, moderate microcytosis and some polys had toxic granules.

Laboratory Work		Normal
CO_2	*21 vol %*	*56-65 vol %*
Blood chlorides	*96*	*350-390 mg %*
		100-110 meq/l
Potassium	*5.85 mql/l*	*4.6-5.6 meq/l*
Total protein	*4.97 grams %*	*6.3-8.0 grams %*

The urinalysis revealed one plus albumin, two plus acetone, 2-3 hylin casts per low power field, a few pus cells and RBC's. The specific gravity was 1.010, pH 5.5. The patient received 5 pints of blood and 3000 cc of fluid during the time she was in the hospital. The fluids consisted of 1000 cc D-5-W to which had been added 5 cc of 50% magnesium sulfate. This was given to control twitching and seemed quite adequate. The second liter was 5% dextrose in saline, and the third was dextrose in water. Her color became quite good, but then she began having difficulty with mucous. Suction was done as often as every 5-10 minutes to maintain a clear airway. In addition ethel alcohol was used in a vaporizer to reduce the tenacity of the mucous, and nasal oxygen was given at the rate of 5-6 liters per minute. Her urinary output had been quite adequate until midnight. She expired suddenly seventeen hours after admission. No other information was given. It was thought the mechanism of her death could well have been simple cardiac overload. It was noted that there was no distention of her neck veins to indicate she was in cardiac failure. The final cause of death was: anemia, hyperchromic microcytic secondary to pregnancy. There was no autopsy.

Comment: This case demonstrates the reason to insist on state-wide hospital deliveries. Unfortunately some mothers are still lost having had a spontaneous delivery. The medical profession can't compel patients to be delivered in

(Continued on page 218)

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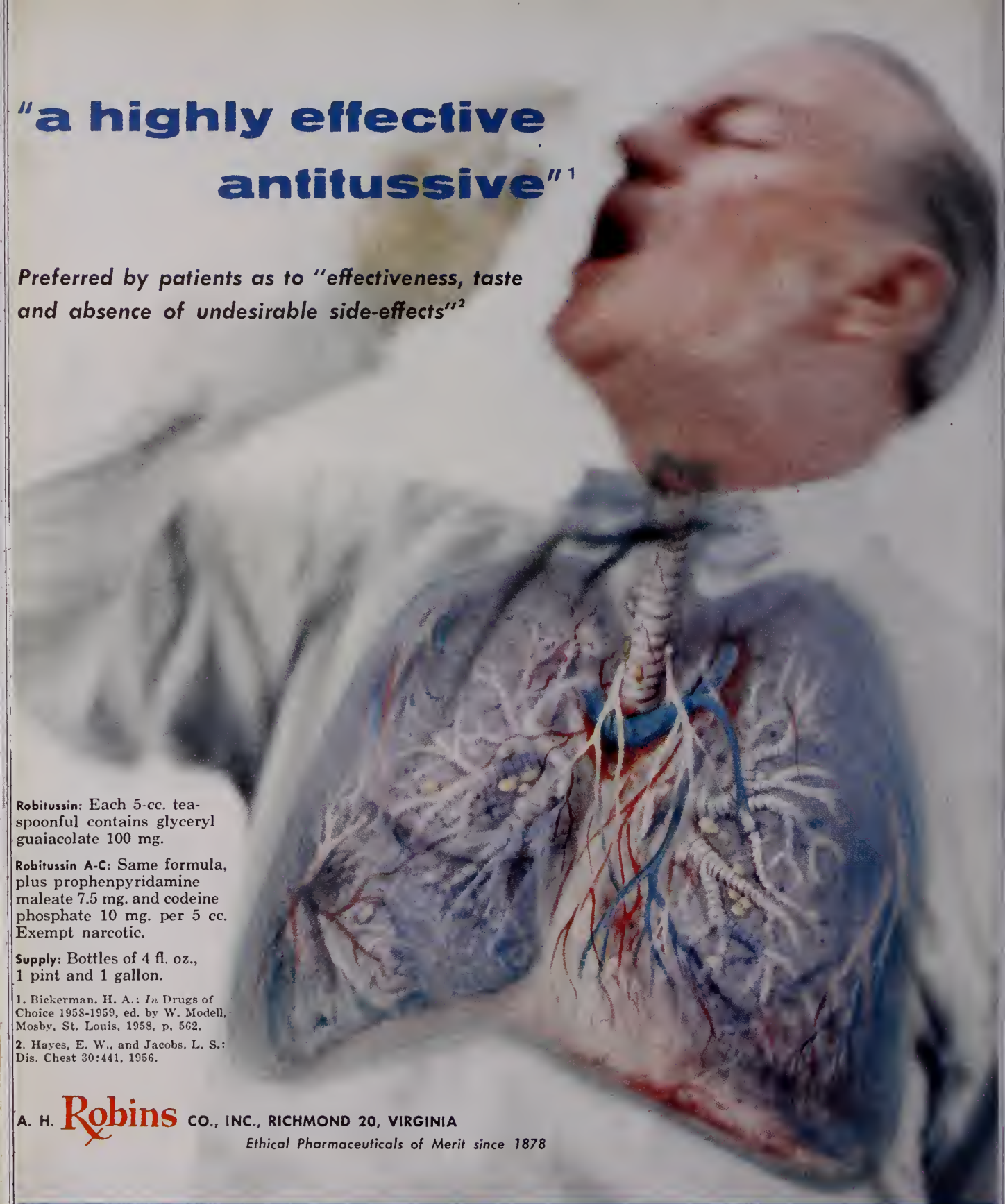
Kaolin (90 gr.)	6.0 Gm.
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1. Bickerman, H. A.: *In* Drugs of Choice 1958-1959, ed. by W. Modell, Mosby, St. Louis, 1958, p. 562.

2. Hayes, E. W., and Jacobs, L. S.: Dis. Chest 30:441, 1956.

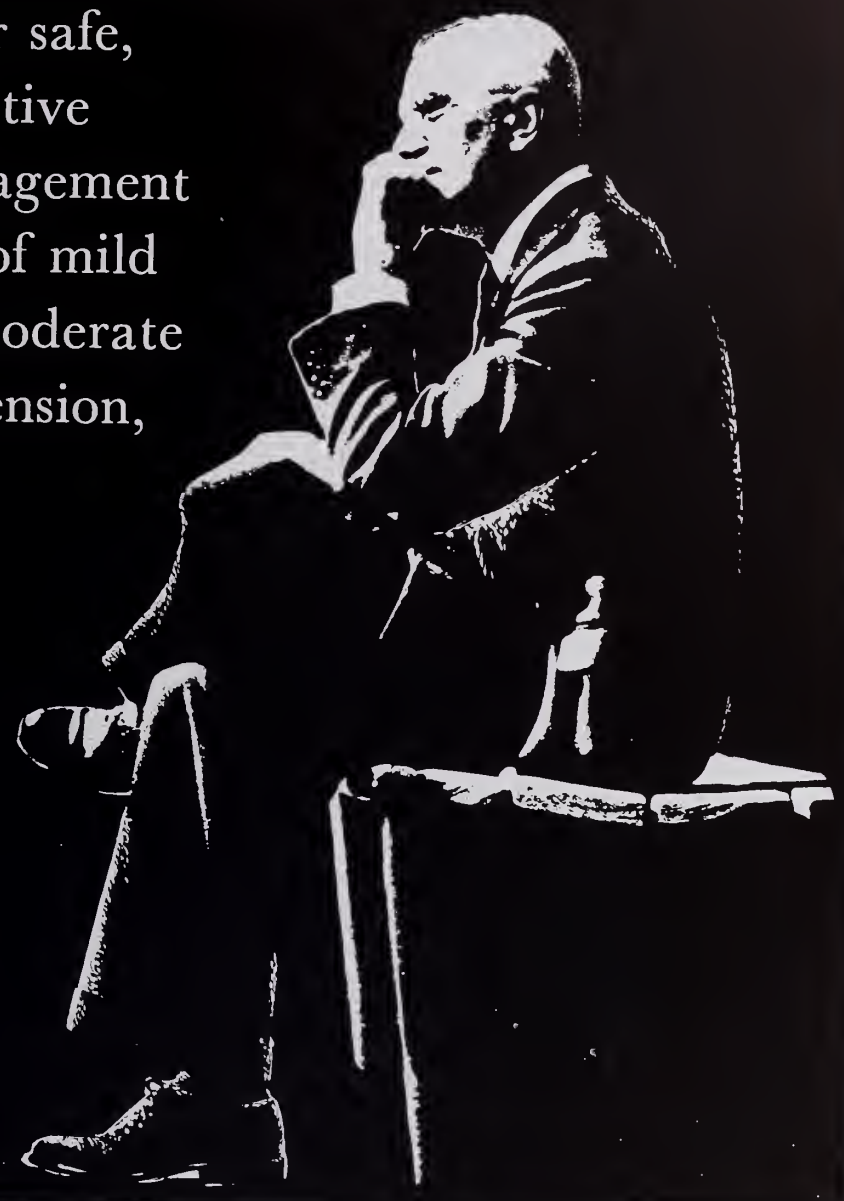
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WASHINGTON NEWS DIGEST

Washington, D.C.—Since the release last summer of the much-discussed Bayne-Jones report on medical education and research, the administration has been reviewing the situation and the possible need for Congressional action on federal aid to the country's medical schools.

Just how strong is its case is likely to be determined in the session of the 86th Congress now underway. In the closing phases of the 85th Congress, a health subcommittee of the House took up the subject amid a feeling at that time that proponents had failed to achieve a sense of urgency.

Another year has rolled around, and the climate may be different. The Bayne-Jones report revived the medical school aid issue. Not since the six-year-old report from the Magnuson Commission has a medical report been quoted so extensively. The Bayne-Jones report calls for a doubling of medical research spending by 1970 and the immediate start on at least 14 new medical schools.

Secretary Flemming of Health, Education, and Welfare let it be known soon after taking office last summer that he was not going to allow the report to be "put on the shelf to gather dust."

In an address to the American College of Surgeons, Surgeon General Leroy Burney sketched briefly a plan for another consultants' group not unlike the Bayne-Jones committee. It is now looking into the question of need for more physicians in the next decade. No date has been set for the final report. At its first meeting in December, the committee authorized two staff studies to get underway: on construction costs of newer schools and on the financing of present-day medical school operations.

Chairman of the group is Frank Bane, former executive secretary of the Council of State Governments and active in public affairs for more than 30 years.

Other members include Dr. Edward L. Turner, American Medical Association's council on medical education and hospitals; Dr. Ward Darley, Association of American Medical Colleges; Dr. Julian Price, AMA trustee; Dr. Edwin L. Crosby, American Hospital Association; Dr. Vernon Lippard, Yale medical school dean; John McK. Mitchell, Pennsylvania medical school dean; Dr. Isador S. Ravdin, Pennsylvania medical affairs vice president; Dr. Clayton G. Loosli, Southern California medical school dean; Dr. Charles E. Smith, University of California public health school dean; Morris Thompson, president, Kirksville College of Osteopathy and Surgery. Also, Harold Hillenbrand, DDS, American Dental Association; Miss Marion Sheahan, National League for Nursing; Dr. Harold L. Enarson, Western Interstate Commission for Higher Education; Emory Morris, DDS, president, Kellogg Foundation; Douglas E. H. Williams, Dunbar Community Association; Fred C. Cole, Ph.D., Tulane; Robert C. Anderson, Ph.D., director, Southern Regional Education Board; Alvin C. Eurich, Ph.D., vice president, Fund for the Advancement of Education; John G. Searle, president, G. D. Searle & Co.; and the Very Rev. Robert J. Slavin, president, Providence College.

Its final report in all likelihood will have a strong influence on the course of legislation.

Notes:

The Office for Dependents Medical Care has decided that this year's contracts for medicare between the Defense Department and state medical societies and other groups will be negotiated by mail. ODMC felt that the whole field had been pretty thoroughly gone over last year and furthermore that administrative costs are no longer an issue. States will be supplied copies of proposed department changes in contracts 45 to 60 days prior to expiration dates, according to Brig. Gen. Floyd L. Wergeland, head of medicare.

The National Air Pollution Conference held in Washington is beginning to produce results. HEW and the auto industry have worked out an agreement on research into devices for controlling auto exhausts. Exhaust experiments are underway at the Robert A. Taft Sanitary Engineering Center on animals, plants and bacteria.

Federal workers contributory health insurance proposal has taken a new lease on life. The AFL-CIO Government Employees Council which speaks for half a million civilian employees is suggesting the following: (1) the U. S. would pay for two-thirds of basic insurance up to a maximum contribution of $14 a month; the worker would pay the balance and could also broaden coverage for himself and family by paying the extra cost himself, (2) there would be a choice of basic insurance such as commercial Blue Cross, Blue Shield, employee union plans, (3) the government would pay the full cost of major medical insurance but the worker would have to have basic coverage; catastrophic coverage would meet 75% of costs.

Congress has failed in past years to enact legislation. Among the reasons has been failure of the various interested groups to get together on a single bill.



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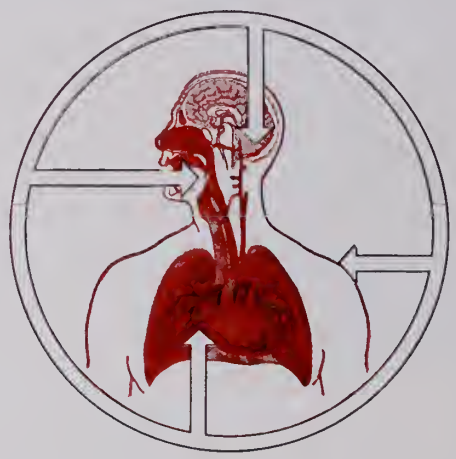
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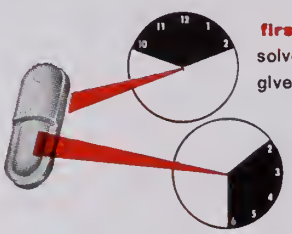
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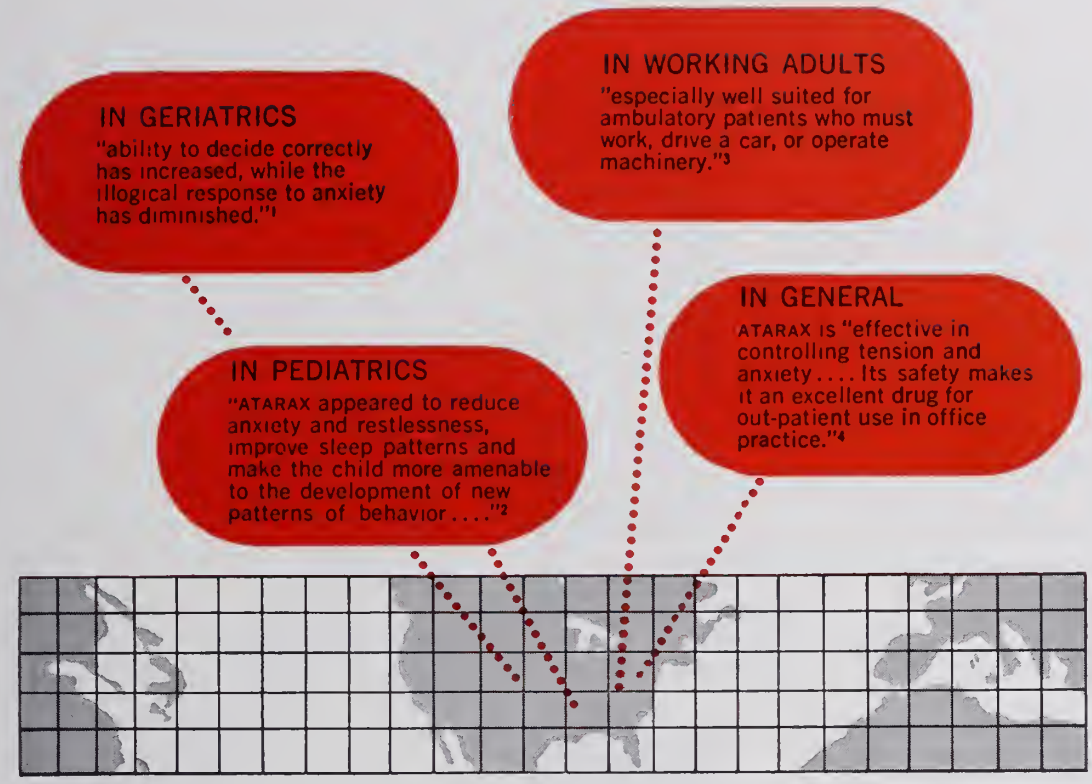
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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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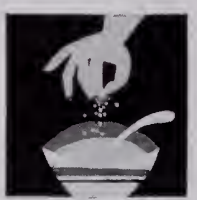
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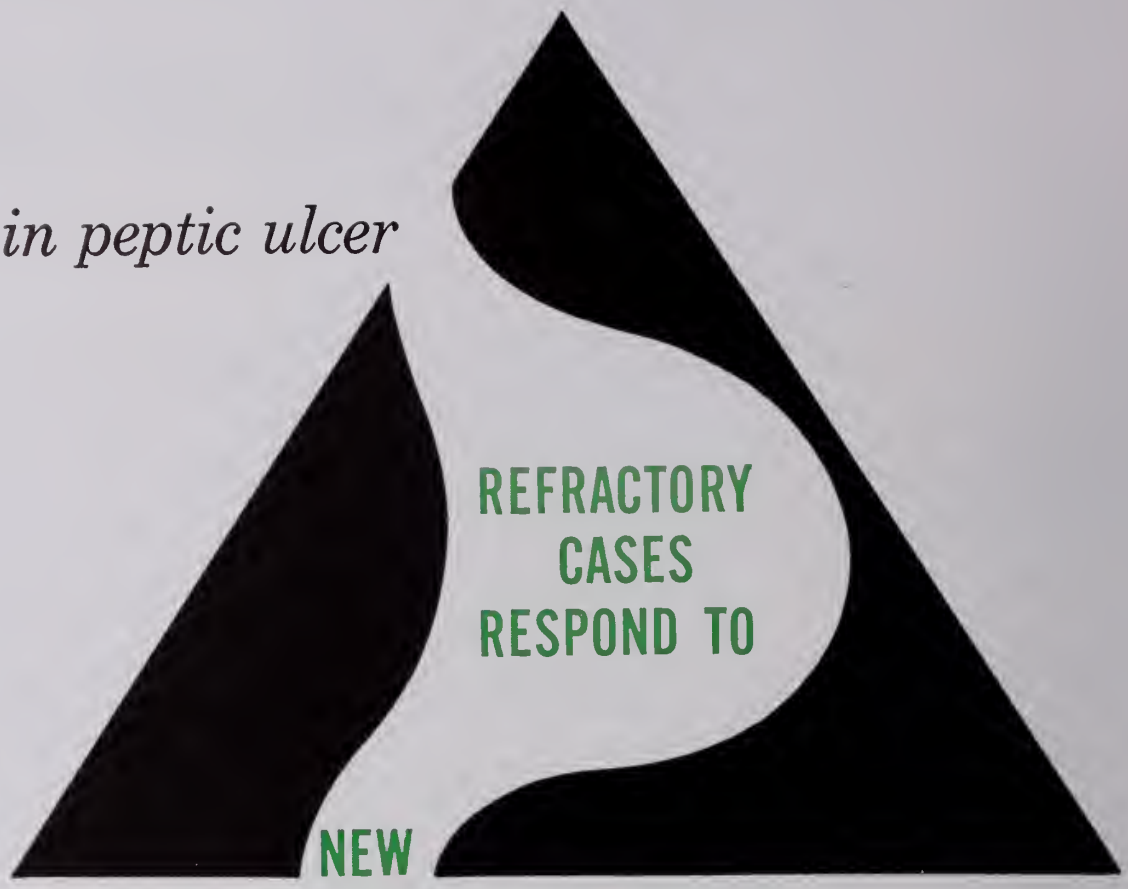
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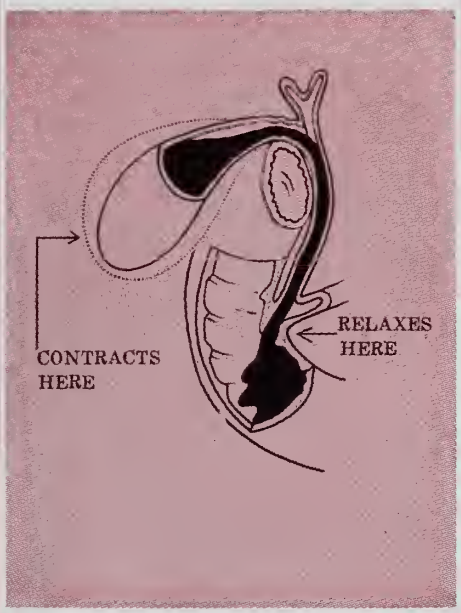
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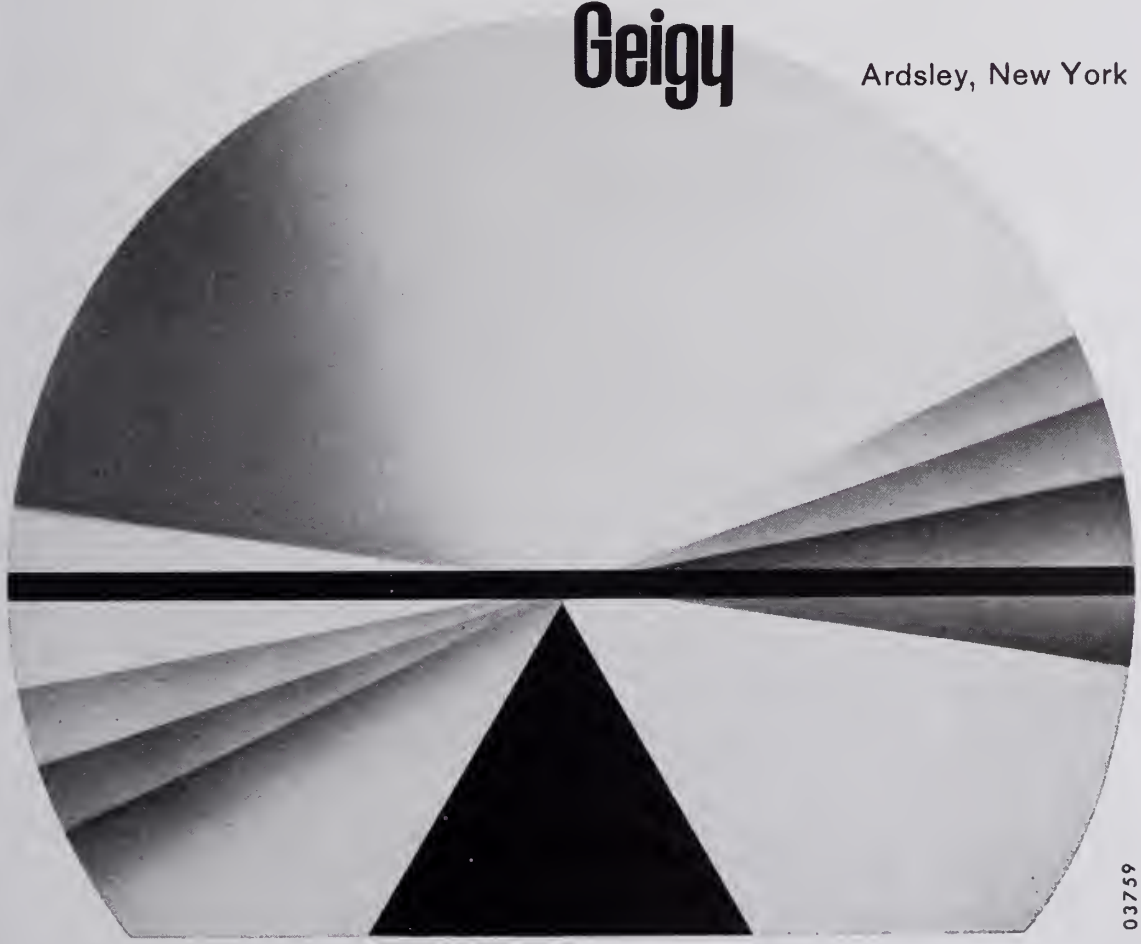
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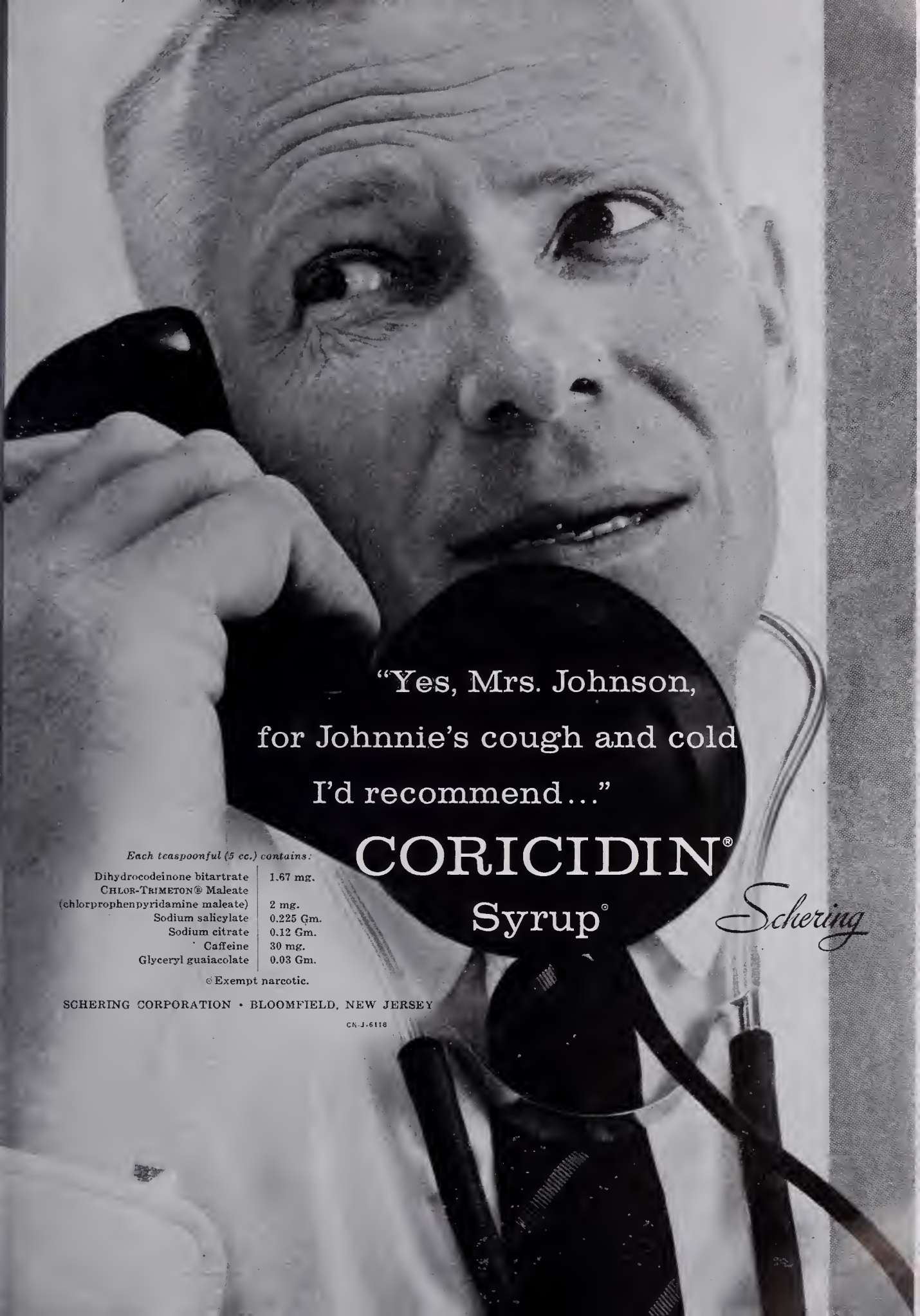
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1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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Pregnancy In The Congenitally Malformed Uterus

JOHN L. KEYES, M.D.

Lexington, Ky.

IN the last sixteen years I have seen seven patients in my private practice with more or less complete duplex anomalies of the uterus, each of whom had one or more pregnancies (a total of twenty).

Embryologically, the uterus and vagina are formed by the fusion of the two Müllerian ducts. The ovaries, on the other hand, originate independently from the Wolffian ducts and therefore exhibit independent anomalies, chiefly those which have to do with imperfect sex differentiation. All pelvic anomalies arise from an arrest of, or perversion in, development: the chief cause being a disturbed nutritional balance due partly to unfavorable environment but chiefly to an inherent defect in the germ plasm, with heredity playing a predisposing part.

The union of the Müllerian ducts takes place from below upward and all degrees of lack of fusion may be noted, there being three cases on record where two complete, but single and distinct, parturient canals with two vulvas were found. It is not rare to find the fundus uteri indented in the middle the—"uterus arcuatus" —which is the upper end of the line of fusion of the two ducts. The two sides of the uterus are not always equally developed and one side may lie as an appendage to the well developed side.

Through our knowledge of embryology, attempts have been made to fix the time during development when uterine anomalies are most apt to occur. According to Schattenberg and Ziskind, unilateral or bilateral failure of development may occur during the first month, while uterus didelphys, with double vagina and uterus, may form during the second month because of failure of fusion of the two sides. Arrested development on one side may give rise to a rudimentary horn. Uterus bicornis or uterus arcuatus may form during the third or fourth months because of incomplete fusion of the two Müllerian ducts. The septum may persist or a single or double cervix may develop. Schattenberg and Ziskind remark that the only malformation that occurs after the fifth month is uterus arcuatus.

Uterine malformations may be found alone or in association with other malformations, most commonly those of the urinary tract. Philpott and Ross did a complete urinary tract investigation on six of their patients and four showed gross urinary tract anomalies in association with those occurring in the genital tract. I regret that none of my patients had a urinary tract investigation. However, none exhibited any symptoms referable to the urinary tract.

There are three times in life when the presence of uterine malformation is likely to be noted. First, at adolescence, when some menstrual disturbance brings the patient for examination, and the anomaly is discovered. Second, at the time of marriage either because of dyspareunia or some other marital difficulty or in the course of premarital examination. Third, it may be discovered by the physician during pregnancy, at the time of the antepartum examination or during labor. The lowest occurrence of the anomaly will be found in studies done for obstetric admissions, where the diagnosis has often been missed, and the highest occurrence will be found in routine hysterographies.

Philpott and Ross from the Royal Victoria

Montreal Maternity Hospital reported that out of 39,190 admissions with a definite diagnosis of pregnancy in a twelve year period, there were 41 patients in whom a definite congenital abnormality was found. There were 56 pregnancies in this group. Fenton and Singh diagnosed 62 uterine malformations in 60,788 deliveries while Eastman had 12 cases in 35,000 deliveries.

Types of Uterine Anomalies

Between the premature uterus didelphys and the almost normal uterus arcuatus, a large number of uterine anomalies are possible.

This has led to complex and unwieldy systems of classification. Jarcho has found that a list of seven variations will include most cases of uterine anomaly. His classification is the one most followed today. He lists the following types: (1) uterus didelphys; (2) uterus duplex bicornis bicollis, vagina simplex; (3) uterus bicornis unicollis, vagina simplex; (4) uterus septus; (5) uterus subseptus; (6) uterus arcuatus or cordiformis, and (7) uterus unicornis. Since each type listed in this scheme represents a distinct stage or phase of development, it is quite simple to fit any variation of form into the proper category. Uterus didelphys, in which there is duplication of the vagina, cervix and uterus is very rare. Cases of this type are usually reported in great detail when discovered.

Diagnosis

Patients, even with the complete anomaly, seldom show external stigma. Vaginal septums are of many varieties and may easily be misinterpreted as artefacts resulting from previous childbirth. Any notable irregularity in the vaginal wall should suggest the possibility of the double anomaly elsewhere in the tract. Simple bimanual examination is not apt to clarify the situation in the absence of other suggestive manifestations in the lower tract. Metal sounds, while they cannot be used in pregnancy, are of the greatest assistance in enabling one to gain accurate concept of the actual situation within the uterus and cervix. Uterosalpingograms yield the most complete information but are not advisable in cases of pregnancy or if adnexal infection is to be differentiated.

Early diagnosis is missed more often than made. Repeated unexplained abortion is to be suspected. Menstrual irregularities are not uncommon and dyspareunia is occasionally a

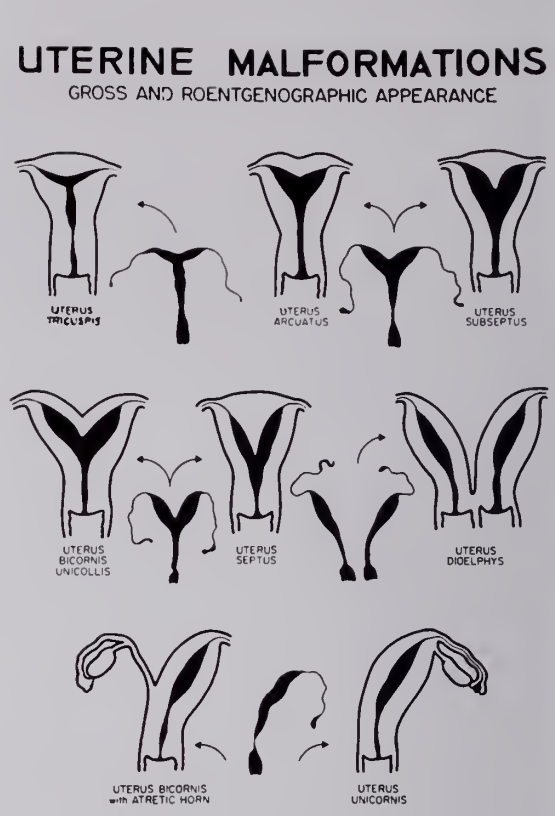


Fig. 1. Different types of the anomaly.

symptom. It is a mistake to regard a history of normal pregnancy and delivery as excluding the diagnosis. Unexplained or repeated breech or transverse presentation may be suggestive.

Management

Pregnancy may occur in one or both horns. If each horn contains an ovum, the two children may have been conceived at different impregnations and be delivered at intervals, thus raising the question of superfetation.

In women with a double uterus, the proportion of twins is definitely greater than in normal women. Beckeley, Bonney and MacLeod point out that with a normal single uterus the ratio of twins is 1 in 89, whereas with double uterus it is 1 in 12. The case you read about in the newspaper in which twins are born days apart may be a case of pregnancy in a double uterus. When there is a pregnancy in each side a double Cesarean section may be indicated.

The first consideration in management involves the advisability of allowing or advising the patient with frank anomalies of this sort to become pregnant. Fertility is generally high but the incidence of abortion is high. The seven patients I have had have had seven abortions in twenty pregnancies, an incidence of 35%. Schauffler had a group of eleven pa-

tients, seven from his own practice and four from the medical school, who had a total of thirty-two pregnancies. There were seventeen abortions or 53%. Miller states that 60% of patients with this complication who become pregnant are likely to go to term, and 30% of those who go to term have complications of some sort. In this group twelve pregnancies went to term and ten or 80% had complications, if one considers a breech to be a complication. My experience substantiates the opinion of Falls, Miller, Findley and others that if the patient is willing to assume the additional dangers of pregnancy under such conditions, she should be allowed to do so.

There is seldom a correct indication to remove an accessory horn, at least not in the interest of later pregnancies, and pregnancy in such a crippled uterus should be considered precarious. The advisability of obliterating an intrauterine septem by excision or electrosurgery is questionable.

The physiology of the nonpregnant horn is of interest. It may enlarge to two to three times its normal size. Decidua is laid down in the nonpregnant horn. This decidua is subject to the same hormonal influences which control the actual pregnancy and such a uterus may not be expected to bleed normally at any time during pregnancy. When irregular bleeding occurs it should be considered as reflecting damage to the chorionic tissue of the pregnancy itself.

In the later months of pregnancy the uterus should be kept under careful surveillance. Malposition of the fetus due to irregularity of contours of the fundus is frequent. Also, it is important to follow the location of the accessory horn if possible. The accessory horn usually rises out of the pelvis as the pregnancy progresses but occasionally may prolapse under the other and act like a tumor incarcerated in the pelvis.

Labor is often normal but may be complicated, first, through interference with the presenting part; second, because of faulty powers; and third, by retention complications. Generally the more extensive the malformation the higher the incidence of complication.

Uterine inertia is described as a common occurrence in labor though it was not prominent in this group of cases. Mechanical disarrangement of muscle fibers logically results in dysfunction of uterine muscle action. Often the chief difficulty involves failure in the mechanism of cervical dilation.

Difficulties in the third stage should be anticipated but frequently do not occur. An adherent placenta due to poorly developed decidua over the septum may present difficulties. The placenta may be trapped in one horn of the uterus as it was in two of my cases. Many authors have remarked upon the high incidence of retained placenta and the necessity for manual removal. Hunter has given the incidence as 11%. Hemorrhage may result from uterine inertia resulting in retarded involution.

Low cervical Cesarean section is not practical in these cases and it is safer to make a longitudinal incision higher in the uterus. In this way you avoid the septum and make delivery of the placenta easier.

Several authors have reported a higher incidence of congenital anomalies in the babies. Fenton says there is no doubt that the babies are generally smaller even when there is certainty that the pregnancy progressed to full term.

Pregnancy in a Rudimentary Horn

This is an exceedingly rare condition. In about 75% the rudimentary horn has no connection with the uterus. However if there is an open tube connection, pregnancy may result from external migration of the ovum or spermatazoa. Clinically, pregnancy in a rudimentary horn resembles a tubal pregnancy. Owing to the weak musculature of the rudimentary horn rupture usually occurs early in the second trimester, but it may occur earlier or later. When rupture does occur, the symptoms are essentially the same as described for ectopic pregnancy: recurring attacks of abdominal pain, fainting, tenderness, and vaginal discharge and discharge of decidua from the normal born.

The most valuable differential finding in distinguishing this condition from tubal pregnancy is the palpation of the round ligament lateral to the mass on the involved side. However the diagnosis is seldom made and the patient is usually operated on for a ruptured tubal pregnancy.

Treatment consists of the removal of the pregnant horn. This is usually not difficult but rarely the sac may be so intimately at-



Fig. 2. Uterus bicornis unicollis in case 1.

tached to the more normal horn that hysterectomy is necessary.

Case Reports

Following are the case reports on the seven patients I have had with a double uterus.

Case 1. I did not see this patient during her first two pregnancies but she gave a history of having had a spontaneous abortion at three months in her first pregnancy and of having lost twins at six months in her second pregnancy. When I first saw her she stated that her last regular period was three months before but she had been having periods of irregular bleeding since. On examination it felt like there was a slightly enlarged uterus on the left with a mass about the size of a three months pregnancy on the right. I advised operation thinking she had an ovarian cyst and at the operation the mass on the right was found to be a three months pregnancy and the mass on the left side a bicornuate uterus. She was closed and went to full term. Three days before delivery the baby was presenting by the breech and I easily converted it to a vertex by external version. She delivered spontaneously an eight pound infant. Her next pregnancy she went to full term and had an assisted frank breech delivery, the baby weighing seven pounds and eight ounces.

I did not see her in her fifth pregnancy but she had an incomplete abortion and had a curettage. Two weeks later she had to return to the hospital because she was still bleeding and had to have a second curettage. I had her again in her sixth pregnancy. Near term the baby was lying transversely and I converted



Fig. 3. Lateral view of the same.

it to a vertex by external manipulation. The next time I saw her it was again lying transversely. She was at term so I sent her to the hospital. The head was easily brought over the inlet and a tight abdominal binder applied. Intravenous Pitocin was started and she developed good labor. The head did not come into the pelvis as it was poorly flexed and it was a large baby. A "low cervical transverse" Cesarean section was done. The baby weighed eight pounds and eleven ounces. The uterus contracted after the baby was delivered and the placenta was trapped up in the right horn of the uterus. It was removed with some difficulty. A classical section would have been better here. Tubes were not ligated, so she may be having other children. She made an uneventful recovery from the section.

CASE 2. The patient has had three spon-



Fig. 4. Uterus duplex bicornis unicollis, vagina simplex.

taneous abortions, one at two months, one at three months, and the last one at four months. She had a curettage after the last two abortions.

CASE 3. This girl was born with an imperforate anus, the intestinal tract emptying into the vagina just posterior to the cervix. At age two she was operated on and a new opening was made in the perineum. As she got older it retracted and now the opening was just in the edge of the vagina. She was perfectly continent and had good results from her operation. When she got pregnant it was felt that Cesarean section was indicated. At term the baby was presenting by the breech. A classical Cesarean section was done. She had a double uterus with a septum extending from the fundus about three fourths the way to the cervix. The baby was lying in the right side of the uterus. This case illustrates the point that where there is one anomaly there are apt to be others.



Fig. 5. Uterus septus in case 3.

CASE 4. I did not see this patient in her first two pregnancies. In her first pregnancy she had a stillbirth at eight months. It was a breech delivery with a prolapsed cord. In her second pregnancy she had an incomplete abortion and a D & C. The operating surgeon made a diagnosis of submucous fibroid at the operation. Her third pregnancy I delivered a full term infant as a frank breech. Two years later I saw her because of dyspareunia and irregular bleeding. On examination I felt the two masses with the larger one on the left. I recommended laparotomy not recognizing that it was a double uterus. At laparotomy she was found to have a double uterus with the division in the fundus extending down to the cervix. Since she had had a normal pregnancy nothing was done.



Fig. 6. Uterus bicornis unicollis, vagina simplex in case 5.

In her fourth pregnancy she went to term and had a low forcep delivery. Her fifth pregnancy resulted in the delivery of a footling. Pregnancy was in the left uterus. Postpartum tubal ligation was done the following day. No X-rays were done on this case. The uterus was of the type "uterus duplex bicornis unicollis."

CASE 5. Cases 5 and 6 are sisters, each with a double uterus. Throughout her first pregnancy the infant was lying transversely. The contour of the fundus showed a definite dimpling at the top. A double uterus was suspected. When labor started the baby was still in a transverse position and one arm prolapsed. A classical Cesarean section was done. A five pound twelve ounce infant was delivered. She had a bicornuate uterus with the septum extending almost to the cervix. In her second pregnancy she also had a transverse presentation and a classical section was done before labor started. A bilateral Pomeroy tubal ligation was done.

CASE 6. Sister of case 5. Married nine years without becoming pregnant. Sterility work up showed the two complete uteri with one external os. She is now five months pregnant and has had an uneventful pregnancy to date. The pregnancy is in the left uterus. Type of delivery will have to be determined at term or when labor starts.

These are the only cases I have seen reported of sisters with double uteri and possibly illustrates the heredity factor.

CASE 7. I did not have this patient in her first pregnancy but she gave a history of a



Fig. 7. Case 6. Two complete uteri with one external os. Each side was injected separately. Uterus duplex bicornis unicollis, vagina simplex.

normal delivery. She stated that the doctor told her that he had trouble delivering the placenta and it came in pieces. At term in her second pregnancy the baby was presenting by the vertex and there was a dimpling in the fundus of the uterus suggesting a double uterus. She had a low forcep delivery and the placenta was retained. When I attempted to remove it manually I discovered that she had a septum extending from the fundus about three fourths of the way to the cervix. The placenta was in the right horn of the uterus and partially adherent to the upper part of the septum. It was separated with some difficulty and removed intact. She had an uneventful post partum course. I do not have an X-ray of this uterus but it would fall into the uterus subseptus type.

Summary

1. In the last sixteen years seven patients with duplex anomalies of the uterus have been seen. Each has had one or more pregnancies—a total of twenty.

2. Early diagnosis is more often missed than made.

3. Uterosalpingograms yield the most complete information available.

4. Fertility is high but abortion is frequent. Most patients may be allowed to become pregnant but should be made to understand the potential difficulties.

5. In this group there were seven abortions, one still-birth at eight months, eleven living children, and one patient is undelivered.

6. There were five breech presentations, four vertex presentations one of which was converted by external version from a breech, and three transverse presentations.

7. There were four Cesarean sections in this group, on two occasions upon the same person.

8. At delivery, operative equipment for the management of vaginal and cervical anomalies, and for Cesarean section if indicated, should be immediately available. Complications of the third stage must be borne in mind.

ADDENDUM

Case No. 6

This patient went into spontaneous labor at her thirty-fourth week of pregnancy. She had an eight hour labor and was delivered of a three pound fifteen and a half ounce female infant. The placenta was delivered without difficulty. She had an uneventful convalescence and the baby was discharged after it had attained a weight of five pounds.

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Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible.

—Sir William Osler

Some Medical Emergencies Of The Newborn*

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THE response of the newborn to various medical emergencies is unique and requires special knowledge. It is the purpose of this discussion to present some of these problems.

Respiratory Disease

By far the major problem in the newborn and premature is respiratory. The most common cause of death due to prematurity is in effect due to immaturity of the respiratory mechanism.[1] Our efforts along this line have been far from fruitful. We teach and practice clearing the airway, adequate respiratory movement, and an adequate supply of oxygen. These indeed are prime requisites since lack of any one of the three is fatal. Respiratory disease may be due to local infection or sepsis, which I plan to consider as a special problem, brain hemorrhage, and hyaline membrane disease.

Intracranial Bleeding

The prognosis in intracranial bleeding is dependent upon the extent of the bleeding. These infants are usually premature or the bleeding is the result of some abnormal mode of delivery—precipitous, high-forceps, breech delivery through a borderline pelvis, or by Caesarean section—all increasing the incidence of intracranial bleeding. These children usually do poorly from birth. They often are quite flaccid and the Moro reflex is absent or sluggish.

Therapy should be directed towards prevention at delivery. After delivery handling should be kept to a minimum and the baby's head should be level with his body or slightly raised, never lower. Oxygen may be administered as needed. Prognosis must be guarded although recovery may be complete or may be followed by cerebral palsy.

Hyaline Membrane Syndrome

The other chief respiratory problem is hyaline membrane disease. A typical clinical syndrome has been described as follows: Usually a premature, one born by Caesarean section or one born to a diabetic mother, has progressive respiratory difficulty that usually is not noted until thirty minutes to four hours after birth.[2] This difficulty is usually manifested by increase in rate and inspiratory retraction. Rales may or may not be heard. Therapy is threefold: oxygen, moisture and antibiotics. The outcome is usually known within 24 hours though death has occurred after 48 hours. These latter patients usually show polymorphonuclear infiltration as well as the hyaline membranes and the resorption atelectasis.

Jaundice

Jaundice in the newborn may be entirely benign or a warning signal of a serious disease. Physiologic icterus is usually not noted until 36 hours; peaks at three days, and disappears in a week. Jaundice before 24 hours, on the other hand, is always pathologic and usually due to hemolytic disease of the newborn. This in turn may be due to Rh or ABO sensitization. In the former the Coombs' test is always positive but usually negative in the latter.

Anticipation is the key to the problem. Early exchange transfusion has improved greatly the prognosis.[3] Our criteria for exchange in the Department of Pediatrics has been a cord bilirubin of 7 mg. % or above, cord hemoglobin of 14 gms. % or below, early clinical jaundice, moderate-to-marked edema, and a large liver and spleen. The indirect bilirubin should be followed every 12 hours and exchange transfusion is done when the level reasonably may be assumed to be approaching 15-20 mgm. %.

Differential diagnosis includes sepsis, cytomegalic inclusion disease, toxoplasmosis and congenital syphilis. Lately, the production of hyperbilirubinemia by doses of vitamin K in the range of 5-10 mgm. per day has been called to our attention.[4]

Bleeding

The third most common symptom is bleeding which when massive is usually associated with sepsis or trauma or both. Petechial bleeding on the other hand again points to hemolytic disease, cytomegalic inclusion disease, thrombocytopenic purpura, congenital leukemia, or other bleeding dyscrasia.

*Read at the joint meeting of the fourth and sixth Councilor Districts of the KSMA at Mammoth Cave, Kentucky, June 12, 1958.

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Sepsis

Of some of the special problems of the newborn period, the most important is sepsis. The diagnosis of this complication is quite difficult and is usually made on suspicion only. By the time the diagnosis may be made by a positive blood culture, the patient is usually terminal or has died. The things which may point to this diagnosis as a possibility are a history of "unsterile" delivery, infectious disease in the mother, lethargy in the baby, poor feeding, respiratory difficulty, convulsions, vomiting of blood, and diarrhea. The physical examination is no more helpful as it may not, and often does not, reveal anything of significance. The temperature may be normal and although the white blood count may be of a polymorphonuclear leukocytosis, this finding is normal in the newborn.

The usual bacterial causes are the hemolytic staphylococcus aureus or the colon bacillus. Once the diagnosis is suspected the use of penicillin or erythromycin and chloramphenicol is justifed.

Diarrhea

Diarrhea as a symptom may be part of sepsis as described above, or may be due to enteric infection. The latter is usually a result of enteropathogenic E. coli. The recommended treatment is neomycin sulfate or chloramphenicol.

Time does not allow the discussion of further medical emergencies but I should like to call your attention to problems of the placental dysfunction syndrome,[5] and babies born to diabetic mothers.[6] These two conditions require special consideration.

Summary

Some of the medical emergencies of the newborn period have been discussed. Treatment in some instances has been outlined. The special problem of infections due to staphylococcus aureus hemolyticus and the enteropathogenic E. coli has been related.

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We are here to add what we can to,
not to get what we can from, life.

—Sir William Osler

Convulsive Disorders Of Children*

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CONVULSIVE disorders in the pediatric age group are exceedingly common and constitute one of the most frequent neurological problems that a pediatrician sees in his practice. This paper is a brief summary of the diagnosis and medical treatment, not a comprehensive review of this broad subject.

Any definition of epilepsy will evoke some criticism, for many persons use the term interchangeably with convulsive disorder while others limit it to describe a specific type of convulsive disorder. For this discussion I will use the term to describe a chronic convulsive disorder of variable type and of unknown origin without any demonstrable evidence of any organic brain lesion.

Incidence and Classification

Convulsive disorders are common, but just how common they are in incidence is difficult to say because of terminology. Most workers in the field agree that about 7 per cent of all children will have at least one convulsive episode. They also all accept five-tenths of one per cent as the incidence of epilepsy in the adult population when utilizing the definition for epilepsy that I just gave. In his series of 4,158 patients from Johns Hopkins Hospital,[1] Livingston found that slightly more than half, 53 per cent of the patients, had idiopathic epilepsy. If we accept that series as representative and extrapolate from it, we can conclude that seven out of every eight children with convulsions will not have them as adults. This fact certainly gives an excellent prognosis for the individual patient. No generally acceptable figures are available for the youngsters with "secondary epilepsy" or organic convulsion disorders, but most certainly their prognosis for being seizure-free as an adult is much poorer.

The classifications of convulsive disorders are manifold. McQuarrie[2] divides them into non recurrent or acute seizures, and recurrent or chronic seizures. In the first group would fall febrile seizures, seizures due to hemorrhage, toxins, and cerebral edema, just to mention a few. The latter group would include seizures from idiopathic epilepsy, organic brain lesions, and congenital lesions. Livingston[3] divides the convulsive disorders into primary and secondary epilepsy but excludes breath holding spells and simple febrile seizures from either group. Personally I find it easier to put all idiopathic disorders in a primary group and include all else in the secondary group.

There are three usual ways to classify the idiopathic group of convulsions. One is clinically to divide them into grand mal, petit mal, psychomotor seizures, and focal or Jacksonian seizures. Another method is to classify them according to their electroencephalographic pattern. Yet a third way is to classify them according to the clinical-anatomic classification of Penfield,[4] which utilizes the postulated epileptogenic focus.

Diagnosis

In diagnosing epilepsy as in all of medicine, the history is one of the most important tools available. First of all, in the history one is interested in knowing if anybody in the family has had epilepsy. The place of heredity in the pathogenesis of epilepsy is difficult to assess, but Lennox[5] in his long, intensive studies has found the incidence of epilepsy in near relatives of epileptic patients to be 6.4 times greater than in the population at large. He also has shown in his work with Gibbs[6] that 60 per cent of the relatives of the epileptics will have an abnormal E.E.G. One study of twins, by Conrad,[7] showed that 86 per cent of monozygotic twins both had idiopathic epilepsy as compared with only 3.1 per cent in dizygotic twins.

Knowledge of the prenatal life of the patient and the details of delivery are obviously of paramount importance. A history of anoxia or cranial trauma is of particular significance. In one large series[8] 15 per cent of all the convulsive patients were found to have their seizures on the basis of cerebral damage at birth. Many of these patients do not manifest their convulsive disorder for a period of years after delivery.

Another general factor in the history that is of diagnostic aid is the patient's age at the onset of his seizures. Figure 1 is taken from McQuarrie's[9] work on epilepsy and shows etiology of seizures at various ages.

*Presented at the Fall Clinical Conference of the Lexington Clinic on October 25-26, 1957.

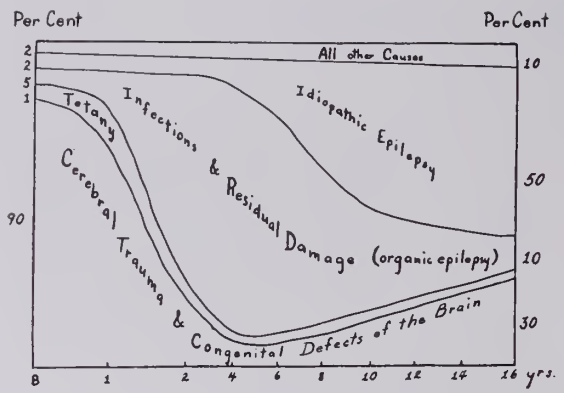


Fig. 1. Etiology of epileptic seizures at various ages.

An accurate description of the seizure itself is essential if the doctor is to diagnose the patient properly. Everybody is familiar with typical grand mal seizures, but it is important to remember that they are frequently modified by therapy. In adults they commonly have an aura, but only one-third of the children will have this phenomenon. All of the children will have a post convulsive period of depression or drowsiness which helps differentiate true grand mal seizures from breath holding spells or hysterical seizures.

Other Forms of Seizures

Infantile myoclonic seizures, or minor motor seizures, consist of dropping the head and flexion and adduction of the arms. They last just a second and most typically occur many times during the day. Baird and Borafsky[10] found that 86 per cent of their patients with this type of seizure had an I.Q. of less than 50.

Petit mal epilepsy, on the contrary, occurs in patients with a normal or high normal I.Q. and has its onset most often between four and eight years of age. Interestingly, in one large series[11] the ratio of females to males was three to one. Most typically petit mal seizures come on suddenly without an aura and consist of staring or rhythmical three per second clonic movements. They last five to fifteen seconds, and the patient has no post seizure depression or confusion. Of the patients with petit mal, 40 per cent will have an associated grand mal epilepsy. One frequently hears it said that patients with petit mal will outgrow their seizures at puberty; almost all of those who follow epileptics have not found this belief to be true.

To the pediatrician, psychomotor seizures are the rarest type of convulsion. They also are the hardest to diagnose, for they consist of bizarre motor or mental activity with a clouding of consciousness and an amnesia for the event. They last for variable periods, usually a number of hours.

Jacksonian or focal motor seizures are most often secondary to some type of organic cerebral lesion, but Livingston[12] found 5 per cent of his 2,224 patients with idiopathic epilepsy had focal seizures. In this short paper I will not list the manifold causes of organic epilepsy.

Differential Diagnosis

The laboratory studies that should be used in evaluating the patient with epilepsy include the following: serology, CBC, urine, blood calcium and phosphorous, NPN, fasting blood sugar, skull roentgenograms and electroencephalography. These studies are all utilized to rule out the various unusual types of secondary epilepsy which would necessarily require different anticonvulsant therapy.

I will say just a brief word about some of these tests and the diseases or syndromes they are useful in diagnosing. The serology, of course, is used to detect congenital syphilis, which is a very rare cause of seizures today. Hypocalcemic seizures (tetany) are most common in infancy. During the neonatal period they are probably due to a transient parathyroid insufficiency and later in infancy are associated with rickets. Hypocalcemia also is seen as a cause of seizures in chronic renal failure. It is important to remember that hypocalcemic seizures can be focal. The seizures due to hypoglycemia can also be focal. They are rare and usually are due to excessive insulin in a diabetic, to pancreatic tumor, or to functional hypoglycemia. The routine urinalysis and NPN are utilized to exclude renal disease. In acute nephritis the seizures are a result of hypertensive encephalopathy, and in chronic renal disease they are due to hypertension or hypocalcemia. Other less commonly used tests of the urine include the test for phenylpyruvic acid and that for coproporphyrin, which are utilized in diagnosing phenylketonuria and lead intoxication respectively.

Skull roentgenograms are helpful in diagnosing such entities as microcephalus, hydrocephalus, tuberous sclerosis, and Sturge-Weber syndrome. Brain tumors are exceedingly rare as a cause of convulsions in children; Livingston[13] found only three patients with brain tumors among his 4,158 convulsives.

The electroencephalogram has proved to be an excellent aid in diagnosing the various convulsive disorders. It is important to remember that it is an aid in diagnosis and not a way of ruling in or out the diagnosis of epilepsy.

Other tests that are not done routinely but do deserve mention are lumbar punctures, subdural taps, and pneumonencephalography.

The "isolated febrile seizure" is a perplexing and important entity, for it is one of the most commonly seen seizures in pediatrics practice.

There is controversy about the classification and prognosis of the patient with a febrile seizure. Husler[14] says that the seizure has no relation to epilepsy, while Livingston[15] and Peterman[16] each found that about 50 per cent of their patients with febrile seizures subsequently developed epilepsy. The typical "febrile seizure" occurs before three years of age and within the first ten hours after the onset of fever. It is rare to have subsequent seizures after 18 hours of fever. Writers on this subject disagree considerably over when to work up and treat these patients. A middle of the road policy would be to work the patients up after they have had two seizures, and then start drug treatment for epilepsy after the third seizure if the E.E.G. is abnormal. Livingston[17] treats only those who have more than four seizures a year, McQuarrie[18] advocates treating them only after they have had an afebrile seizure.

Treatment

Before I discuss specific drugs, it is important to mention a few generalities about therapy. When therapy in pediatrics is begun, it is started with a plan in mind to treat for four to five years. If at the end of that time the patient has been seizure-free for two years or more, the E.E.G. is repeated and the drugs gradually discontinued. If the patient has a seizure while off drugs, he should be placed back on therapy for life. The prognosis for the patient with idiopathic epilepsy is good; 80-90 per cent will be improved or completely seizure-free while on therapy. The prognosis for the patient with "secondary epilepsy" is not nearly as good.

In treating any of these types of epilepsy, one usually starts with the first or first and second drug of choice and then, depending on the results, increases the dose of that drug to tolerance before adding another drug. Patients should be warned repeatedly about the danger of suddenly stopping phenobarbital, for such withdrawal is one of the commonest causes of status epilepticus. In general, it is better that patients should not be on two bone marrow depressants at the same time.

The following is a list of the therapy of choice in the various types of epilepsy:

Grand Mal
Phenobarbital or Mebaral®
Dilantin®
Mysoline®
Mesantoin®
Phenurone®

Petit Mal
Phenobarbital
Paradione®
Tridione®
Benzedrine®
Caffeine
Diamox®
Thyroid Extract—Celontin,® Milontin®

Minor Motor Seizures
Ketogenic diet (children two to five)
Phenobarbital
Ataraxics

Psychomotor Seizures
Dilantin
Mesantoin
Phenobarbital or Mebaral

Secondary Motor (Focal) Seizures
Phenobarbital
Dilantin
Bromides

The specific dosage schedules of these drugs can be found in any text on epilepsy or any general pediatric text.

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How Useful Is Simple Scalene Lymph Node Biopsy?*

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In 1949, Daniel[6] reported a method of biopsy useful in diagnosing certain intrathoracic diseases. This report is intended to evaluate the usefulness of this type of biopsy in cancer particularly in our hands.

Lymph nodes anterior to the scalenus anticus muscle are secondary way stations from the mediastinal nodes; thus, this procedure is a simple way of biopsy of the mediastinal nodes without entering the thorax.

Cervicomediastinal biopsy, as advocated by Harken[8] and associates, has not as yet gained general approval; however, it may be the procedure of choice. In this procedure the mediastium is entered and biopsied by means of a laryngoscope. Drs. Kenney and Mota of Henry Ford Hospital have also utilized this procedure, increasing the positive biopsies by 30 to 50%.

As emphasized by Connar,[4] the description of the lymphatic drainage of the lung by Rouviere indicates that the right lung and the lower two thirds of the left lung drain to the right; whereas the upper one third of the left lung drains to the left side of the mediastinum and neck. This locates the site of incision. However, where there was an overlap or doubt, bilateral biopsy was done.

In reviewing the literature, it was noted that several authors did not indicate, in describing the accuracy, if palpable nodes were found preoperatively. This could account for the high range of diagnostic accuracy reported in their studies. The test of this procedure as I see it is the patient in whom a pulmonary or mediastinal lesion is unassociated with palpable cervical lymphadenopathy and in whom positive scalene nodes would prove both that the pulmonary lesion is cancer and also that it is incurable.

Present Study

After excluding 210 cases of palpable nodes, data on 40 cases were available for the present study. It is important to emphasize that none of these patients had enlarged lymph nodes on physical examination. All had abnormalities in X-ray films of the chest. All were males—34 white and 6 colored. Ages ranged from 22 to 68 years. On admission, the chief complaint was related to the chest in all except 5. The clinical impression was correct in 26, incorrect in 2 and deferred in 12. In this series there were only 4 positive biopsies. This must be qualified because 2 of these cases were sarcoidosis and in one, gastrocnemius muscle biopsy was positive and the diagnosis already made. No muscle biopsy was done on the other sarcoid case. A total of 19 cases underwent exploratory thoracotomy with negative scalene node biopsy. Ten (10) had palliative surgery. Seven (7) were operated on for cure. Two (2) were totally inoperable.

Right scalene node biopsy was done 22 times, and left, 16, including 2 cases who had bilateral biopsies. Results of this study are shown in Table I. Table II shows the results of other studies.

Thirty-three patients had bronchoscopic examination and in 21 cases abnormalities were noted. In only 3 cases was the diagnosis made on the basis of bronchoscopic biopsy specimen. Cytologic studies and bronchial washings were diagnostic in 4 cases, 3 were diagnosed by Silverman needle biopsy, one by smear and culture, one sarcoidosis case by gastrocnemius muscle biopsy, and one metastatic lesion by gastrointestinal series.

TABLE I
Results of 40 Scalene Node Biopsies in 40 cases with undiagnosed lesions in the chest

	Diagnosis From Biopsy	Final Diagnosis by Exploration, Autopsy, Etc.
Carcinoma of the lung	2	21
Metastatic tumor to lung		1
Sarcoidosis	2	3
Pneumonia		3
Pulmonary tuberculosis		1
Fibrosis with giant cell reaction		1
Aneurysm with thrombosis		1
Fractured ribs with pleural effusion		1
Idiopathic pleural effusion		1
Undiagnosed		7

*Published with the permission of Chief Medical Director, Department of Medicine and Surgery, Veterans Administration, who assumes no responsibility for opinions expressed or conclusions drawn by the authors.

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In regard to the chief complaint, 4 had routine X-ray and were told there was an abnormality, one had no complaints referable to the chest, and the remaining 35 had one or more of the following complaints: soreness, pain, shortness of breath, wheezing, asthma, cough, hemoptysis, chills and fever, weight loss and anorexia.

There were no complications in this series following the node biopsy. A 6 centimeter incision was routinely made and the entire operative procedure consumed about one hour of time. A search was always made to identify scalene nodes grossly. Time from admission to open thoracotomy varied from 3 to 27 days. These cases were done from 1954 to January, 1957.

TABLE II

Results of Scalene Node Biopsy Reported by Various Investigators

Author	No. of Patients	Positive Biopsy (per cent)	Per cent of Biopsies with Carcinoma of Lung
Shefts et al	187	35.8	54.0
Piper	185	38.1	19.2
Harken et al	142	31.7	39.8
Schwippert et al	122	12.3	4.9
Beahrs et al	79	43.0	7.6
Jay and Hewlett	74	17.5	22.2
Cartsensen et al	56	64.2	...
Connar	50	28.0	31.0
Johnson	50	10.0	...
Yang	42	59.5	62.0
Cuykendall	41	19.5	21.4
Hall et al	40	10.0	5.0
Umiker et al	29	...	24.0

Summary

Certainly negative scalene node excision does not guarantee operability. Most investigators have felt that mediastinal exploration is a distressing procedure. In this series of 21 cases of carcinoma of the lung, 19 were operated upon with negative scalene nodes. The surgeon found only 7 that were possibly curable, while two were totally inoperable and 10 had palliative resection. Therefore, a more extensive diagnostic procedure should be done preoperatively.

I feel that exploratomy thoracotomy should be done in the beginning without use of scalene node excision or mediastinal exploration.

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Coccygodynia*

(An Analysis of 100 Cases)

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Introduction

PATIENTS with coccygodynia complain of pain in the coccyx and adjacent regions. Thiele,[1] however, has shown that in about 85 per cent of patients the pain occurs, not in the coccyx, but in either the sacro-coccygeal joint or the muscles (the levator ani, the coccygeus and a bundle of fibers from the gluteus maximus) that are partially inserted into the lateral borders of the coccyx.

Coccygodynia has been attributed to neurosis, neuritis, neuralgia, rheumatism, strain, luxation and fracture. Treatment has included: sedatives, antineuritics, antispasmodics, rectal suppositories, hot and cold applications, electrotherapy, massage of the coccyx, radiation therapy and even coccygectomy. Because coccygodynia often occurs after long periods of watching television, I am inclined to coin the term "television bottomitis" for this condition.

Typical Case

Patients with coccygodynia often wish to stand while their histories are being taken. Many sit down cautiously, then repeatedly shift their position from one side to the other. Women seem to be more susceptible than men to this syndrome. Most of them note exacerbation of their symptoms immediately before and during the menstrual period.

Almost without exception, patients say that a long automobile ride or prolonged sitting will cause severe pain. Most patients habitually sit with a poor posture with the lumbo-sacral portion of the back convex instead of concave. They slump in a chair and allow the middle portion of the sacrum and coccyx to press against a chair. The patient usually sits down in and gets up from a chair slowly and carefully. He definitely says that he cannot lie comfortably on his back at night.

Examination

A patient may be examined in the left lateral Sim's position or in an inverted position. The index finger is inserted full length into the rectum. The finger is placed over the coccyx internally, and the thumb over the coccyx externally. The coccyx is palpated and manipulated bi-digitally. In most cases of coccygodynia, a movement of the sacro-coccygeal joint produces severe pain. In some cases, however, according to Theile,[5] the joint can be moved without pain although there is still present a severe levator ani and coccygeus muscle tenderness and spasm. Normally the sacro-coccygeal joint is freely movable, the antero-posterior flexion and extension of the coccyx in relation to the sacrum being about 30 degrees. Thiele adds: "The tip of the coccyx may be normally moved laterally about 1 cm. from the midline. Mobility of the coccyx is therefore not a sign of dislocation or fracture. If a fracture is present, any movement of the bone is extremely painful and crepitation may be felt. An x-ray will confirm the diagnosis.

After the coccyx is palpated in the examination, as described above, the finger is moved laterally from the posterior midline with the palmar surface in contact with the soft tissues. The medial borders of the gluteus maximus and the levator ani and coccygeus are felt as they proceed to their insertion into the lateral edges of the coccyx and lower portion of the sacrum. With moderate pressure, the finger is moved laterally, anteriorly and then medially through 180 degrees until it lies just posteriorly to the symphysis pubis. Thus, one can palpate all of the fibers of the muscles which are inserted into the lateral border of the coccyx.

Thiele has stated: "The most typical and characteristic findings in coccygodynia are muscle tenderness and spasm." The coccygeus muscle is more difficult to evaluate because of an underlying ligament, and may be thought to be in a state of spasm when it is not. When the levator ani is spastic, it is felt as a firm sheet of muscles stretched from its origin in the obturator fascia to its insertion in the lateral borders of the coccyx and lower portions of the sacrum." One often can feel this as a sort of a "bowsting" stretching across this area. If the patient strains down, the spastic levator

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muscles will often relax while being palpated. One should remember that this muscle spasm and tenderness may be unilateral or bilateral. If unilateral, the stress on the sacrococcygeal joint is in the direction of flexion and abduction, and the pain is often more severe on that side. If bilateral, it is in the direction of anterior flexion, according to Thiele.

In the man, the prostate and seminal vesicles should always be palpated. A pelvic examination should be performed on a woman. After a digital examination of the rectum, complete proctoscopic and anoscopic examinations should be performed to determine any co-existing conditions.

History

The patient's history is of great value in diagnosing this condition. In a history characteristic of coccygodynia, the pain is definitely exacerbated by continued sitting, is most severe while rising from a sitting position, and is aggravated by long car rides.

A few exceptions to that general rule are patients in whom pain is due to severe trauma or fracture and rare conditions such as a spinal cord tumor or herniation of an intervertebral disc. In cases of severe trauma or fracture, the pain is increased during defecation. If sudden trauma has been the causative factor, muscle spasm occurs at once and the onset of pain and tenderness is immediately manifested.

Patients often say that hip and leg pain accompanies the pain in the tail bone. It is caused by pressure of an associated spastic piriformis muscle on the sciatic nerve as it emerges through the sacrosciatic foramen and by pressure upon the superior gluteal nerve as it passes between the upper border of the spastic piriformis and the lower border of the gluteus medius.

Approximately one-fourth of my patients complained of associated pain in the upper portion of the gluteal region, or down the posterior portion of the thigh. Examinations of these patients revealed a spastic piriformis muscle.

Freiberg and Vinke[6] and Freiberg[7] have published two excellent papers discussing the relationship of piriformis muscle spasm to sciatica from an orthopedic standpoint. Freiberg's sign of piriformis muscle spasm is limitation of motion on inward rotation of a fully extended thigh.

Etiology

Thiele[5] believes that coccygodynia is due to three definite factors: (1) Direct trauma may cause pain. (2) Continued immobilization of any joint will cause pain if maintained in a position of flexion by muscle tension. In coccygodynia the sacrococcygeal joint is maintained in a state of constant flexion by tension of the spastic levator ani and coccygeus muscles. (3) Muscle spasm itself may be painful. Says Thiele:[5] "We are taught that repeated or sustained muscle contraction results in the formation of lactic acid, which causes fatigue and then pain. Anoxia may also be a factor."

Poor posture may produce muscle spasm if continued over long periods. The spasm is due to a continued over-flexion of the sacrococcygeal joint more than by a direct pressure on the coccyx.

Table 1 gives the etiologic factors in my series and the number of patients in each category. Myositis or reflex spasm of the levator ani, coccygeus, and piriformis muscles may be caused by any focus of infection where the lymphatic drainage is toward the pelvic muscles. In my series, infection was the etiologic factor in 60 cases, as shown in Table 1. The infection was found in the prostate in 3 cases, in the epididymis in1 , in the cervix in 5 and in the anal region in 51.

TABLE 1

Etiologic Factors

INFECTION	60 cases
Prostatic	3 cases
Epidydimal	1 case
Cervical	5 cases
Anal	51 cases
TRAUMA	38 cases
History of fall	18 cases
Fracture	0 cases
Pregnant at time of fall	3 cases
Prolonged sitting	14 cases
Prolonged rides	3 cases
POST-SURGICAL	2 cases
No spinal cord tumors and no herniated disc.	
TOTAL	100 cases

In 38 cases trauma was thought to be the etiologic factor. One can easily elicit a history of some kind of a fall in most cases, but 18 of mine had a definite history of a fall severe enough to cause direct trauma to the coccyx. There were no fractures. Three patients were pregnant when they fell. In 14, prolonged sitting while watching television was definitely thought to be the traumatic factor. In 3 cases, prolonged automobile rides seemed to be the traumatic factor.

Two patients complained of a dull, heavy aching in the lower rectum and the sacrococcygeal area a few weeks after anorectal surgery. This pain was severe enough to be placed in the category of coccygodynia which developed post-surgically.

Method of Treatment

As early as 1910 Ely[8] was massaging the coccyx and its immediate soft parts between his thumb and finger. He said that "usually two or three treatments at intervals of two or three days would suffice to cure the cases."

Thiele[3] has had more experience and contributed more to the literature on coccygodynia than any other author. He describes a very effective method of massage which a great number of proctologists have adopted. Here is his description of the technique: "With full length insertion of the finger into the rectum lateroposterior pressure will place its flexor surface horizontally across the surfaces of the levator ani and coccygeus muscles almost at a right angle to their fibers. The fibers of the piriformis are felt immediately beyond the sacrospinus ligament and are touched by the finger tip in such a manner that lateral motion of the finger will stroke lengthwise that portion of the belly of the muscle lying within the pelvis.

"These muscles are massaged in the long direction of their fibers and in the same manner as a strop is stroked by a razor. Massage is begun lightly. This is necessary because one does not wish to traumatize the extremely tender spastic muscles. The sacrospinus ligament is merely pressed on by the finger in the direction vertical to its long axis. As the patient makes subsequent visits, massage is made with increasing pressure. If a reaction which is evidenced by increased pain is evoked, light massage is again reverted to and pressure is increased as tenderness decreases.

"If definite improvement does not result after the first four to six massages over a period of a week or ten days, orthopedic or other indicated consultation should be sought."

Most of the patients in my series were treated by massage and received an average of six treatments over three to four weeks.

Medical and surgical control of foci of infection was used when necessary. This is reported in the results and consisted of removing chronic anal fissures, hemorrhoids, and fistulas when they were deemed a part of the condition and the pain was not relieved by massage.

I have not performed a coccygectomy and mention it only to condemn the operation as a cure for coccygodynia.

Results of Treatment

As Table 2 shows, 62 patients were treated by massage only, and symptoms were relieved in 80 per cent or 50 patients. Twenty per cent or 12 patients were not relieved by massage.

TABLE 2
Methods and Effectiveness of Treatment

TREATED BY MASSAGE ONLY	62 cases		
Relieved of symptoms	50 cases	(80%)	
Unrelieved of symptoms	12 cases	(20%)	
TREATED BY INSTRUCTIONS IN REGARD TO POSTURE AND HEAT (dry heat or hot baths or both)	28 cases		
Relieved	25 cases	(90%)	
Unrelieved	3 cases	(10%)	
TREATED BY MASSAGE AND SURGICAL REMOVAL OF FOCI OF INFECTION	10 cases		
Relieved	9 cases	(90%)	
Unrelieved	1 case	(10%)	
TOTAL	100 cases		

Twenty-eight patients were treated by carefully instructing them in proper posture, and by heat, which consisted of hot sitz baths two or three times a day and an electric hot pad to the painful areas at night. Of these 28 patients, 25 or 90 per cent were relieved and only 3 or 10 per cent were not. The third group was treated by massage and surgical removal of foci of infection. This group consisted of 10 patients. Nine or 90 per cent were relieved and 1 or 10 per cent were unrelieved.

Summary and Conclusion

It is emphasized that a spasm of the levator ani and coccygeus muscles has been found in patients with coccygodynia. Not infrequently a spasm of the piriformis muscle, with pain in the upper portion of the gluteal region and pain down the back of the thigh, may accompany coccygodynia.

In this series of cases, a reasonably good result was obtained by massaging the spastic muscles and removing the foci of infection when necessary. A determined effort was made to instruct all patients in regard to correct posture. A special effort was made to teach the patients to lean forward and to sit well back in a chair or car seat. The surgical removal of the coccyx has been condemned as a treatment for coccygodynia.

In a series of 100 patients, 62 were treated only by massage, with 80 per cent relieved of symptoms; 28 by instructions for proper posture and by heat, with relief in 90 per cent. Ten

were treated by massage and surgical removal of foci of infection, with relief of symptoms in 9.

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Round Worm Infestation As Seen By The Surgeon*

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SURGICAL lesions initiated by the presence of Ascaris lumbricoides have been described at both autopsy and operation.[1-18] It is surprising to find that so few surgical complications have been described in the English literature, inasmuch as the common round worm is the most wide spread of world-wide helminthic infestations. While cases of Ascaris infestation have been reported in every state, Cort and Otto,[19] demonstrated that the mountains of the southeastern United States, with special reference to the Appalachian chain of Eastern Kentucky and Western Virginia, have the highest infection ratio of any other mountain area. The only exception to this finding was an isolated study of Cuban cigar workers in Tampa, Florida. They pointed out that heavy infestation was related definitely to unsanitary defecation habits and to surface sewage disposal.

Mature worms in the body have been found in the brain,[4] in the thorax,[12, 16] and in the abdominal cavity. It is possible to categorize parasitic damage to the human host as obstructive, allergenic, loss of nutriment, intoxicative, traumatic, lytic and proliferative assaults.[21] It is apparent in noting the following description of surgical lesions and complications, that parasitic activity apparently responsible for these lesions is usually obstructive in origin.

The Worm and Its Cycle

The Ascaris lumbricoides specifically owes its name to the fact that it resembles a large earthworm. The life cycle of the Ascaris has only recently been described, though the large size of the adult worm has permitted descriptions of it for hundreds of years.[22] In 1863, Davaine noted that ingested ova hatched in the human intestines. The definite outline of the life cycle of the worm quickly followed Stewart's observation in 1916 that larva passed through the lungs of mice and rats. One year later Ranson and Foster showed that after the preliminary pulmonary cycle in hogs, the larvae developed to worms in the intestines. The similar migration in man was traced in 1922, by Koino and his brother, Japanese workers. This author ingested two thousand eggs and became ill six days later. Sputum examination revealed the presence of 178 larvae. Systemic symptoms were a chill, fever, headache, malaise, and rapid respiration.

The adult worms normally live in the intestinal lumen, obtaining nourishment from the semi-digested food of the host. Beldring pointed out that nourishment could come from epithelial cells of the intestinal mucosa ingested by the worm.[22] He quoted Yokogawa and Walkeshima as stating that monosaccharides were absorbed from the surrounding media as another source of food.

The life span of the adult worm in a host is usually one year. The sex functions of the worm are performed by simple apposition of the male and female orifices. The female worm has a daily output of 200,000 eggs and a productive capacity of 26 to 27 million eggs. Fertilized ova are usually unsegmented when they leave the host, requiring two weeks of favorable soil and water conditions to fully develop by segmentation into infective embryos. The infective embryos may survive for long periods, up to 5 or 6 years.

When ingested by man, the encysted larvae hatch in the small bowel. These larvae, which measure 200 to 300 micra, follow an "obligatory" path by venous or lymph channels to the lungs. After rupturing into air sacs, the larvae are raised in the sputum and swallowed, thus completing the cycle in the intestines by developing into adult worms. The pulmonary cycle has been explained on the basis that the larvae lack sufficient glycogen to enable them to persist in the oxygen-free intestines. Thus, the oxygen need directs the larvae to the alveolus.

Clinical Syndromes

Clinically, Ascariasis may be divided into two syndromes, that accompanying larval migration and that due to the presence of the adult worm. Larval migration is characterized by fever, eosinophilia, urticarial rashes, and changes locally in the lung and liver. The varied symptoms of the adult worm infestation depend upon the location of the worm and to the number of worms present, yielding most

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commonly a general abdominal discomfort with nausea, colicky pain, digestive disturbances and loss of appetite.

The most common surgical complication of Ascariasis appears to be intestinal obstruction. The presence of a large bolus of intertwining worms is the usual cause.[13] In time disengagement would usually follow, but the diagnosis of intestinal obstruction frequently necessitates laparotomy for relief. The bolus usually develops following a treatment which permits large masses of stunned or dead worms to pile up. It may follow treatment with inadequate drugs which end in frantic attempts by the worm to migrate away from the unpleasant media. Jung and Faust[13] feel the site of obstruction is usually in the low ileum of children who range from the ages of 2 to 4. These youngsters play on infected grounds and suck their dirty fingers. Aiken[20] has pointed out that if intussusception has been ruled out, and if peritoneal irritation is absent with the presence of bowel sounds, then observation is justifiable while hydration and saturation with antibiotics are effected. If re-arrangement of the entangled worms with relief of the obstruction does not follow, oral ingestion of syrup of Antepar,® 1 dram every two hours, for three doses may sufficiently paralyze the worms to permit recovery without surgery. This observation is confirmed by the experience of Swartzwelder, Miller, and Sappenfield.[23]

VanMeter[14] in 1909, reported a successful enterostomy for reduction of a round worm obstruction with recovery of the infant. Morton and Archer[15] in 1932, reported that five persons from a group of 110 persons with diagnosis of Ascariasis were operated on for ileal masses. One of the five required an enterostomy to relieve the obstruction because the bolus was too well fixed to be broken up. The other four were relieved by manual disengagement of the Ascaris bolus. After noting that a second operation could follow manual disengagement of the Ascaris bolus to correct a recurrent obstruction, Ochsner, DeBakey, and Dixon[12] in 1949, suggested that an enterostomy with evacuation was the only safe way to relieve the obstruction.

Intestinal perforation, while rare, was listed as the second most common complication of Ascariasis by Jung and Faust.[13] The cause of the perforation has been debated in the past. Some opinion supported the ability of the worm to pass through a normal bowel wall. Ochsner, DeBakey, and Dixon[12] pointed out that it was possible for the worms to pass through suture lines into the peritoneal cavity. Moore states that any perforation of any portion of the gastro-intestinal tract may occur as a result of the migratory effort of the worms.[16]

Biliary and Pancreatic Involvement

Invasion of the biliary tract by the round worm is less common. The diagnosis of the cause of duct obstruction is usually made at operation when the Ascaris is found. Ochsner points out that the finding of a worm in the gall bladder makes it mandatory that the common duct be diligently explored until one is assured that no worm remains.[12]

T-tube drainage must be carried out in all cases in which the common duct has been explored. Decompression of the biliary tree is the treatment of choice for cholangitis which is present if worms are found. Shore, Lippman, and Weber, in 1954, presented a case of choledochal Ascariasis in which the diagnosis was consistently missed, even after surgical exploration of the common bile duct and operative cholangiography three years after cholecystectomy, until the worm presented itself at the open cutaneous end of the T-tube on the 12th post operative day.[7] Ascaris ova were identified in biliary drainage for a month afterwards, even though the stools were negative. Though Jung and Faust state that biliary tract Ascariasis was third in their study of collected cases, it provided a source for the most voluminous of the literature concerning surgical complications of Ascariasis that was reviewed.[13] Aviles[10] in 1910, found a nidus of Ascarides the center of gall stones. Gallagher[24] in 1930, found the common duct to be obstructed by an adult worm. Yang and Laube,[6] in 1946, described 19 cases of biliary Ascariasis. Butt[9] in 1922, found the round worm in the gall bladder, and relieved his patient's symptoms with a cholecystectomy.

Pancreatic involvement may be foretold by the presence of major upper abdominal pain with retching all out of proportion to the minor abdominal findings. Schmieden and Sebening, in 1928, found an adult worm obstructing the pancreatic duct of a patient who died with acute pancreatic necrosis.[11] In 1953, Evans, Lubben, and Whigham, presented a case who

was found to have a pseudo-cyst of the pancreas of Ascaris origin.[8] The cyst itself consisted of perforation of a small area of necrotic pancreatic tail into the lesser sac. This was treated by external drainage. Moore[16] detailed the findings at autopsy of a four-year-old girl, the cause of death being rupture of the esophagus in three places. Ascarides were found in both pleural cavities. Three worms were found in the pancreatic duct. Hemorrhagic pancreatitis involving the body and tail was present and probably was a precipitating factor. It is perplexing to imagine that even a migratory Ascaride could pass through a tonic sphincter of Oddi. It would be easy to understand that an active thin nosed worm would enter an atonic sphincter of Oddi or an ampulla graced by an absent sphincter.

Appendicitis

Appendicitis has been associated frequently with the presence of Ascariasis. This is a more common finding in those countries in which infestation by the round worm is high. It appears that the obstructive factor in the appendicitis is initiated by the presence of round worm. In 1927, Ludlow drained three right ileac fossa abscesses secondary to a perforated appendicitis[17] and found round worms were present in all three. Another interesting finding was described by Cheng-Hsien. He found three round worms incarcerated in the lumen of an appendix.[13] Overholser and Rentschler, in 1930, described a case of Ascariasis which simulated exactly an attack of appendicitis with recovery of the patient after treatment.[5] An acute Meckel's diverticulitis was described by Paul and Goona Wardena in 1953.[1] This diverticulum was ruptured and round worms were found free in the peritoneal cavity. The child recovered following surgery.

Karlen, 1950, described an autopsy on a fatal case of Ascariasis in which a round worm was found in the ventricle after the brain was opened. The exact mode of transportation by which this organism arrived at this site was not clearly evident.

The presence of intussusception and volvulus has been described as a primary finding by various authors with relief by detorsion or by reduction of the intussusception.

Summary

It is well established that the common round worm is the source of many complications requiring surgical correction. It is evident that these complications are all the result of an obstructive phase occurring during the normal life cycle of the worm. Many of these complications can be cured by surgery, but prevention of them must depend on Public Health epidemiological measures and sanitary disposal of human excreta.

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Hematuria*

Edward H. Ray, M.D.**
Lexington, Ky.

ALTHOUGH every physician in the country surely knows about the serious possibilities that exist in connection with the passage of blood in the urine, many patients with hematuria continue to be treated expectantly by their physicians.

It is not the purpose of this paper to present anything new about bleeding from the urinary tract (for indeed there is nothing new to present) but to sound a warning that needs to be repeated over and over again that hematuria must not be viewed carelessly. It is a condition with serious possibilities and should be viewed with grave concern.

It is not at all uncommon to have a patient, coming in because of a second or third episode of bleeding from the urinary tract, say that at the time of the first episode, perhaps several months earlier, he was given medicine by his physician "to stop the bleeding." That such bleeding stops sometimes is a matter of chance and not due to the medication, unless the bleeding happens to be the result of inflammation of mucosal surfaces due to bacterial infection.

If neoplasm happens to be the source of the bleeding any delay in proceeding with adequate investigation will result in the waste of much valuable time between onset of symptoms and diagnosis and the cost may be the life of the patient.

I well remember a person in my own community who was held under treatment for hematuria by her family physician, in whom she had extraordinary confidence, for six months after she herself had asked if it might not be a good idea to have an examination by a urologist. Such examination, made eventually, revealed the presence of a large, high grade neoplasm in the dome of her bladder. Ureterointestinal anastomosis and total cystectomy was done but the patient died two years later of metastatic carcinoma. It is conceivable that her life might have been saved if the carcinoma had been discovered six months earlier.

Hematuria may be macroscopic or gross and therefore evident to the patient or it may be microscopic and evident only on microscopic examination of the urinary sediment. In either event the significance may be the same.

Causes

Blood in the urine may be the result of certain systemic conditions such as acute fevers, blood dyscrasias, hypertension, glomerulonephritis, or vigorous exercise, and may occur as the result of medications and with the therapeutic use of anticoagulants. More often it is the result of a lesion or lesions located within the urinary tract itself, such as inflammatory processes, tumors, calculi or trauma.

Inflammatory lesions undoubtedly account for more than half of the cases of hematuria, with acute cystitis and/or urethritis in the female leading the way. Posterior urethritis in the adult male, often associated with a cystitis, may result in the passage of blood in the urine and the frequency with which this occurs increases with increasing age.

Bleeding, the result of inflammation, is usually associated with painful micturition although this is not always the case since many times gross painless hematuria will occur in women with diffuse hemorrhagic cystitis as revealed by cystoscopy. On the other hand, bladder tumor is not infrequently associated with inflammation so that it may not be taken for granted in any given case that just because frequent, painful micturition is also present that the condition is due to inflammation alone.

While painless hematuria suggests the likelihood of neoplasm of the bladder, kidney or ureter, it may be the result of inflammation or of nothing more serious than a small ureteral calculus.

The passage of blood at the beginning or at the end of urination with clear urine in between suggests a source in the urethra or at the bladder neck. In the female, conditions which sometimes produce this effect are urethritis and inflammatory polyps while urethral caruncle and inflammation of prolapsed urethral mucosa will often produce blood spotting on the clothing. In the male, posterior urethritis, with or with-

*Presented at a joint meeting of the Ky. Surgical Society and the Va. Surgical Society at the Greenbrier, White Sulphur Springs, W. Va., April, 1958.

**Associate Professor of Urology University of Louisville, School of Medicine.

out polyps or granulations, will usually be found to account for initial or terminal bleeding but in neither sex can this feature be depended upon for the exclusion of neoplasm since there are many instances in which a bladder tumor situated in the base and projecting over the vesical outlet will produce the same effect.

Careful Examination Necessary

Except in the case of obvious acute glomerulonephritis there is no way of knowing definitely what the source of bleeding is in any given patient or what its significance is without a careful urological examination. A tremendous responsibility is placed upon the physician therefore not to procrastinate in seeing that his patients have the advantage of early investigation since there is no other way of being sure that a malignant tumor or other serious organic lesion does not exist.

The urologist himself, with all the expertness derived from special training and experience, often enough will have difficulty in arriving at a conclusive diagnosis when neoplasia is in its incipiency so a plea is made that he be given an opportunity, if possible, to see the patient while bleeding is active instead of waiting for it to subside before referring the patient to him. The appearance on cystoscopy of bloody spurts of urine from one or the other of the ureters may enable him to evaluate better some slight deformity apparent in the pyelogram.

Again let me state that it has not been the purpose of this paper to discuss the subject of hematuria in all its intricate details and many details and causative factors have been omitted or no more than mentioned. It has been my purpose to remind us all of the possible serious if not disastrous consequences to the patient with hematuria if he is not given the advantage of early and adequate investigation. Of less importance is the embarrassment, chagrin and distress which accrue to the physician whose failure to advise his patient properly results in an unnecessary or even tragic delay in the diagnosis of a malignant neoplasm of the urinary tract.

Those who bring sunshine to the lives of others can not keep it from themselves.

—James Matthew Barrie

A Case of Shigellosis

LOUISVILLE GENERAL HOSPITAL

Clinical History

D. T. (LGH #278984), three-year-old Negro female was admitted to the Pediatric Service shortly after midnight 11/14/58 with the chief complaints of fever and convulsions.

History of Present Illness

The history obtained from the patient's mother revealed that the child had been in her usual state of health until approximately twelve hours prior to her hospital admission. At about 10:00 A.M. 11/13/58 the patient was noted to be restless and felt warm to the touch. A little later she complained of a "Stomach-ache" and was given aspirin and castor oil. She remained fretful but became lethargic during the rest of the day. She was anorectic but did drink liberal quantities of fluid. Her mother thought she had repeated "chills" during the day and evening. About one-half hour before hospital admission the patient developed a generalized tonic and clonic convulsion and was immediately brought to the hospital.

Physical Examination

At the moment of arrival the child was having a grand mal seizure so 1½ grains of sodium amytal was given intravenously to stop the convulsion.

Examination then revealed a semicomatose Negro female in no acute distress but who would only respond to painful stimuli.
T.—104(R) P.—180 R.—48 BP 70/30-0
Wt.—29 lbs.

There was no evidence of dehydration and the remainder of the complete physical examination was remarkable only in the lack of abnormal findings except as noted above. At that time the differential diagnosis included: 1. Bacillary Dysentery, 2. Sepsis, 3. Meningitis, 4. Pneumonia.

Clinical Course

As soon as the convulsions were controlled and the history and physical examination completed the specimens for the diagnostic laboratory procedures were obtained.

1. The white blood cell count was 7,200/mm^3 of which 60% were polymorphonuclear cells, 40% were lymphocytes.
2. The urinalysis was normal.
3. A spinal puncture was performed and the manometrics and examination of cerebral spinal fluid was entirely normal.
4. A series of three blood cultures.
5. Three rectal swabs for culture.
6. A nasopharyngial culture.
7. Roentgen examination of the chest revealed no pathology.
8. Tuberculin and histoplasmin skin tests were applied. (subsequently negative)

Due to the possibility of sepsis Chloramphenicol (50 mgm/K/d), Gantricin (120 mgm/K/d) and aqueous potassium penicillin G (20,000 u per K) every three hours were started.

Sponge baths and intravenous fluid therapy were started to help control the temperature. Approximately nine hours later the child developed green, watery diarrhea. As the temperature had not come down as desired ice packs were ordered. A second convulsion occurred before the temperature came down. After the ice packs took effect they were used intermittently to control the body temperature, and no more convulsions occurred.

The following day the laboratory confirmed the diagnosis of Shigellosis, and the penicillin therapy was discontinued.

Within twenty-four hours the child was markedly improved and then had an uneventful convalescence. Therapy was continued for one week, and rectal cultures performed a week after discontinuation of therapy were negative.

Discussion

Dr. William Curtis Adams: This patient presented with the problem of an unexplained fever of one day's duration. The lack of sig-


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Tetracycline with Citric Acid *LEDERLE*

ERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

nificant physical findings coupled with convulsions does, however, suggest a few conditions seen relatively frequently among children. The first of these, Roseola infantum or exanthem subitum, was not given much weight in this case as it is a disease seen characteristically during the first year of life. When Roseola infantum is present the patient usually has an unexplained high fever for approximately seventy-two hours without a visible physical explanation. Many such patients do have convulsions during that period. The fever may not respond well to the usual methods of temperature control. The white blood cell count may reveal a leukopenia with a relative lymphocytosis. The responsible virus is not isolated by usual methods. The diagnosis is confirmed by the appearance of the transitory maculopapular rash associated with a sudden lessening of the fever between the third and fourth day.

In our experience Shigellosis in young children presented more frequently with high fever often with associated convulsions than as a diarrheal disease. The diarrhea occurs later in the course of the illness. The specific reason for the convulsive disorder associated with Shigellosis is unknown but is most generally considered to be toxic in origin; however, the organism has been found in the blood and bone marrow. It is of interest to note that the child three or four years of age is more likely to have convulsion associated with Shigellosis. The isolation of the organism by culture of material from tract or other areas proves the diagnosis.

Infections of the central nervous system, urinary system, and the lung fields and blood stream are notorious "hidden" causes of fever. In each of these cases appropriate laboratory or roentgen investigation will reveal the disease. Convulsion in such cases occurs most frequently with infections of the central nervous system, but do occur in the other conditions particularly in patients known to be subject to febrile convulsions.

As shown with this patient when the problem of unexplained fever is presented to the clinician he must be aware of the possibilities and take the appropriate diagnostic steps early in the course. The seriousness of some of the causes is great enough (meningitis and septicemia) to demand appropriate cultures before therapy is instituted.

A urinalysis is very important. The usual urinary tract infection would be revealed as would diabetes, etc.

A white blood cell count and differential may offer significant suggestive information.

Roentgen examination of the chest should reveal any pneumonic process. It is surprising how many pneumonias are not demonstrable with the stethescope even when the area is specifically known.

Blood cultures (usually three separate specimens collected at intervals of a few minutes) are extremely important if bacterial sepsis is suspected.

Appropriate examination of the cerebral spinal fluid must be accomplished if central nervous system disease is considered.

Clinical Course

Alex J. Steigman, M.D., As noted above the diagnostic steps listed were taken for this patient as the initial step after the control of convulsions and continued support of the patient's respiratory exchange had been established. Anti-microbial therapy for possible sepsis was then instituted designed to treat the most likely causes of bacterial sepsis in this age group.

It is of interest to note that the more usual signs of dysentery developed within a few hours of the initiation of therapy and within twenty-four hours the bacteriological studies made it possible to specifically treat Shigella flexneri.

Until recently sulfadiazine has been the therapeutic agent of choice against all forms of the Shigella family. Recent reports from all parts of the earth indicate the emergence of a resistant strain of each member of the Shigella family.

Types of Shigella (Pathogenic)

Sh. dysenteriae
Sh. flexneri
Sh. sonnei
Sh. ambigua
Sh. boydii
Sh. large sachsii

As a result, a combination of sulfadiazine and tetracycline or chloramphenicol seem indicated at the present time.

Although often considered geographically restricted experience indicates that Shigellosis occurs in all parts of the U.S.A. with relative frequency.

(Continued on page 220)

SPECIAL ARTICLES

Report of the KSMA Delegates on the Interim Meeting* of the AMA, Minneapolis, December 2-5, 1958

ROBERT C. LONG, M.D., DELEGATE
Louisville, Ky.

Conference on Federal Medical Services

W. VINSON PIERCE, M.D., Senior AMA Delegate from Kentucky, George P. Archer, M.D., Alternate Delegate to the AMA, Mr. Joseph Sanford, Executive Secretary of the KSMA, and Robert C. Long, M.D., Junior AMA Delegate from Kentucky attended the interim session of the American Medical Association held in Minneapolis from December 2 through 5, 1958. On December, 1, 1958, a day-long meeting sponsored by the Committee on Federal Medical Services dealing with the Veterans Administration Hometown Medical Care program and Medicare was held. Mr. Sanford and Doctor Long were instructed by the Committee on Federal Medical Services of the KSMA to attend the meeting.

This meeting was panel in type and following topics were discussed. First, the future of Hometown Medical Care programs for the veterans. The object of this discussion was to determine the best method of administering hometown medical care for the service-connected veteran. It was brought out in this discussion that any physician who is duly licensed to practice medicine in his state may be a participating physician in the Hometown Medical Care program for the veterans by simply applying to the Veterans Administration for the privilege of being a participating physician. Once this has been granted, he then looks after any veterans that come to him and there is, of course, a fee schedule which covers the fees that he may charge and collect from the Veterans Administration for such care that is rendered.

States Differ

Some states have a very active Hometown Medical Care program for the veterans, as was brought out by Doctor Gifford of Pennsylvania. For example, in that state 2483 physicians participate in this program and in the year 1957 cared for 38,000 patients. The cost of this care from the Veterans Administration to the physician was $322,000 or $8.62 per patient in twelve months. Both Pennsylvania and other states discussing this—California particularly—have an intermediary or fiscal agent, which in these two cases has been Blue Shield.

One of the points that was emphasized in this discussion was the value of having an intermediary to act for the physician rather than have the physician deal directly with the Veterans Administration. The value of an intermediary, we think, is quite obvious. The intermediary could adjudicate more favorably and more advantageously with the Veterans Administration on differences of opinion or problems arising from this program. An intermediary could determine with the Veterans Administration a schedule of fees. These are things that it was felt from this Conference could be better handled by an intermediary rather than by direct contact of individual physicians with the Veterans Administration.

It was further brought out in this discussion that there is a great deal of apathy amongst the several states in regard to the Hometown Medical Care program for the veterans and since the principles upon which the Hometown Medical Care for Veterans is based is so in keeping with our concept of the best practice of medicine, that is, doctor-patient relationship, choice of physician, remaining at home for care rather than staying in a distant place hospitalized often where it might not be necessary, et cetera, it was the feeling of this Conference that greater emphasis should be made in the various states to expand the Hometown Medical Care program for veterans wherever possible among the various states.

As far as Kentucky is concerned, there is in existence a Committee on Federal Medical Services, Leon Higdon, M.D., Chairman. This committee is now in the process of negotiating a new fee schedule with the Veterans Administration. Kentucky, however, does not have Blue Shield or any other intermediary acting between individual physician and the Veterans Administration.

Topic Discussed

The next topic for discussion at this Conference was posed in the form of a question: "Are education and research essential to Veterans Medical Care?." There was a great deal of discussion and controversy concerning this matter. Those who felt that programs and research were not essential to veterans medical care brought out the fact that this was very expensive. In other words, intern and residency programs and research increases the cost to the taxpayer of hospitalized Veterans Administration costs, and it

**W. Vinson Pierce, KSMA's Senior Delegate to the AMA will report on the AMA's Annual Session.*

was the feeling that this was not justified especially because the procurement of interns and residents by the Veterans Administration drained these people from teaching centers and other hospitals throughout the country which have such a shortage of interns and residents already. On the other hand, those who felt that intern and residency training and research were essential to veterans medical care brought out the fact that if the veteran was to receive the best medical care, this type of care must include intern and resident for the best care of the patient, and they felt also that research was a very necessary part of good medical care.

Free Choice

The remainder of the Conference was taken up with the problems of Medicare. Brigadier General Boyd L. Wergeland, who is the Executive Director of the Office for Dependents' Medical Care, was the principal speaker and gave a very well organized and complete historical review from the inception of Medicare up to the present time. As we all know, for budgetary reasons there has been a rather marked restriction in the Medicare program. General Wergeland brought out the fact that 134 million dollars has been expended on Medicare since its inception on December 7, 1956, and as we know, the budget for the fiscal year 1958-59 is approximately $72,000,000, which even operating within the restrictions imposed upon it by Congress will not be sufficient funds to cover the cost of Medicare.

As you know, the problem of restriction or curtailment of free choice of physician is that which is of the greatest concern to organized medicine, and freedom of choice of physician has been curtailed as a result of budgetary restrictions of the Medicare program. Because of this the AMA has gone on record as of this meeting urging Congress to provide adequate funds so that the Medicare program may be put on the basis that it was on prior to the restrictions of October 1, 1958.

Proceedings of The AMA House of Delegates

The remainder of this report will be concerned with the proceedings of the House of Delegates of the American Medical Association. It will be understood that it would be impossible, or almost impossible, to fully report on every action taken by the House of Delegates. Therefore, your delegates have felt that possibly the best way to conduct this report would be to highlight or report those actions taken by the AMA House of Delegates which were either particularly appropriate to organized medicine or were of greater importance. For simplicity and organizational purposes we will report the actions of the House of Delegates by reference committee recommendations and action by the House.

This committee noted that there was a new book on parliamentary law. This book, which the committee studied and recommended for study by all members of the House, was found to be complete, concise, simple and acceptable in every respect. The author, Alice F. Sturgis, has made a life-long study of the subject. This reference committee recommended that the state and county societies should familiarize themselves with this new book so that it may be possibly used at the county, state, and national levels at a later date. The only other matter of importance brought before this committee, and being important enough to be reported by us, was a special report of the Council on Constitution and Bylaws pertaining to service members. As you are aware, there are many difficulties surrounding the question of service memberships. The House of Delegates of the AMA in San Francisco in June of 1958 expressed the desire that all service memberships should be subject to the same eligibility requirements. The fact that the various states and county societies have different eligibility requirements for membership makes this problem very complex. This committee, therefore, recommended and the House adopt the following resolution: That the House of Delegates of the AMA urge all component societies to make every effort to provide a type of membership for armed forces, public health service, and Veterans Administration physicians, which will enable them to become active members of constituent societies and of the AMA.

Insurance and Medical Service

We shall next consider material that came under the reference committee on Insurance and Medical Service. As many of you know, for the past three or four years there has been within the framework of the AMA a Commission on Medical Service Plans. The duty of this Commission was to study all types of third-party medicine in the country. This would include the more familiar Blue Shield plan and other types of open panel plans as well as all types of closed panel plans including such plans as the Kaiser-Permanente and the United Mine Workers Welfare Association plans. It was the duty of this reference committee to digest the report of this Commission and to make its recommendations. Both Doctor Archer and Doctor Long attended the reference committee meeting since this was so pertinent to one of our major problems in Kentucky. It was our feeling and both so spoke before the committee that final judgment on this report of the Commission on Medical Care Plans should be deferred until the June meeting in Atlantic City.

Your delegates took the position of deferment because this is a really monumental piece of work; involves approximately four years of study by the Commission; it is embodied in two volumes of 120 pages each; and we felt that there had been insufficent time to adequately and comprehensively study this report. Doctor Pierce felt very strongly that we should ask for deferment on any action until either the Council of KSMA or the special committee recently appointed by the Council to study third-party medical plans could adequately study the findings of the Commission and so instruct your delegates if we are to take whatever action would best serve the physicians of Kentucky.

Project Deferred

We are delighted to report that this was the feeling of a great many other people also and the recommendation of the reference committee to the House was one of deferment on this very important project until the June meeting in Atlantic City. In addition, the constituent associations were urged to study this

report especially in regard to free choice of physician and closed panel systems and to forward their replies to the AMA 60 days in advance of the June 1959 meeting.

The House of Delegates of the AMA again reaffirmed its very positive position in regard to Veterans Administration facilities. This stand, which we are sure most of you are familiar with, states that Veterans Administration facilities should be used only for the care of service-connected diseases and disabilities of veterans, and that the care of non-service connected disabilities should be the responsibility of the individual, or if he is medically indigent of his community or state. It further stated that until existing law is changed the priority for any non-service connected care provided should go to those suffering from illnesses or disabilities which are economically catastrophic.

Hometown Medical Care

In regard to veterans affairs, the House also urged the continued study of the Hometown Medical Care for Veterans, which we have eluded to above, and suggests that the material derived from the Conference on Federal Medical Services, December 1, 1958, be made available to the medical profession as soon as possible. This reference committee called particular attention to some statistical data which we feel you will find very interesting. It is estimated that by 1986 the service connected patient load will decrease to 23,600 of which 22,000 will be for psychiatric care, while the non-service connected load will increase to 304,500 if present admission policies are not altered. We think that you can see from these figures that there are many great problems that confront medicine in regard to Veterans Administration medical care.

We are happy to report that a new and very important committee on insurance and prepayment plans has been appointed within the Council on Medical Services and that Doctor Pierce is a member of this committee. This committee will study insurance problems in the following fields: Blue Shield, private carrier health insurance, life insurance, disability insurance, professional liability insurance, Blue Cross, and consumers' sponsored plans. This is an extremely important committee and Kentucky is indeed fortunate in having Doctor Pierce as a member of this committee. On the other hand, few people have had more experience in these fields than Doctor Pierce, and this committe of the AMA should be commended in having a man of Doctor Pierce's ability to serve on it.

In regard to Medicare, the official action of the House of Delegates was to the effect that it regretted the curtailment in the Medicare program, and it hoped that the new Congress would restore Medicare to its former position. The reason organized medicine has taken this position is that under the present Medicare set up, there are rather marked restrictions on freedom of choice of physician.

One of the greatest problems confronting medicine today is the problem of the aging, or the problem of our senior citizens. This was brought out very effectively by the President of the AMA, Doctor Gunnar Gundersen, and it was also brought out very effectively by the address of the Governor of Minnesota, the Honorable Orvell Freeman. As a matter of fact, it impressed us that Governor Freeman made a major policy speech before the House of Delegates of the AMA, and in this speech he specifically asked organized medicine to help government in solving the problem of the aged, which means in effect, of course, to solve the problem of the financial burden of taking care of old people in regard to illness and disability.

Response to Challenge

In response to this challenge by both Doctor Gundersen and Governor Freeman, your House of Delegates took the following action: That the AMA, the constituent and component medical societies, as well as physicians everywhere, expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 years of age with modest resources or low family income; that physicians agree to accept the level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate.

The next reference committee is the one on Legislation and Public Relations. Rather surprisingly there was only one resolution concerning Social Security that was introduced to this House. This was a resolution from Ohio which contains the results of a poll by the Ohio State Medical Association concerning the coverage of physicians under Social Security. As most of you know, the results of this poll were very definitely in favor of Social Security. There are approximately 9000 physicians in Ohio and each one received a questionnaire.

About 75% to 80% of these physicians returned the questionnaire and there was a rather surprising majority of votes in favor of Social Security. As this resolution was informational only, it was not necessary that any action be taken in regard to it. The reference committee recommended that the results of this poll be transmitted to the Board of Trustees for information and for the information of any of the Councils or Committees of the AMA concerning this matter, and this was adopted by the House.

Bills Enacted

It will be of interest to all of us to know that of the 15 bills of a medical nature enacted into law by the 85th Congress, only one was opposed by the AMA; and that in a statement to Congress the AMA was supporting legislation or principle involved on 19 occasions and was in opposition on only 6 occasions. The reference committee went to to say that "we believe that these facts should be publicized to the American public and the medical profession in order to help eliminate the often heard charge that the AMA is basically negative in most legislative matters." The Jenkins-Keogh bill which failed to be enacted by the 85th Congress will be actively supported by the Council on Legislative activities in its continued effort to secure enactment of this legislation.

The principal topic that was considered by the Reference Committee on Miscellaneous Business

(Continued on page 208)

EDITORIALS

The Need Is Urgent

TEN years ago the Red Cross opened its Regional Blood Center in Louisville. It began operation as a result of the action taken by local medical societies and the Greater Louisville Hospital Council.

Since that time the Blood Center has supplied close to a half-million pints of blood in the 33-county area which it serves.

The first day the Blood Center was open for business, the Red Cross collected 22 pints. Today it is necessary to collect at least 200 pints a day to supply doctors and hospitals with the blood they need. The cost to the Red Cross for collecting, processing and transporting blood is $5.52 for each unit. At present, the Red Cross is bearing this entire cost.

Money to finance the Blood Program and other Red Cross services must come from the 1959 Red Cross Campaign in March.

Doctors who depend upon Red Cross for the blood they need should be especially aware of the urgency of a successful campaign.

William Bizot, M.D.
Chairman, Medical Advisory
Committee, Regional
Blood Center

It's Your Responsibility

ADDED impetus has been given to the importance of polio immunization in recent months by the American Medical Association, the U.S. Department of Public Health, the State Department of Health, as well as by the Council of the KSMA.

Of special note is a recommendation passed by the AMA House of Delegates at its interim meeting in Minneapolis which was endorsed by the Council of the KSMA and sent to all county society secretaries in December.

The recommendation asked each physician to assume the responsibility for making certain that all members of the families he serves are protected by having three full doses of polio vaccine. Without this cooperation from every physician full immunization against polio will never be an actuality. This request then, is something that every KSMA member should feel is a duty he must perform for his profession as well as his patients.

Figures taken from the last survey made in the state reveal that 40 per cent of the persons in the state under age 20 had not received all three immunization shots against polio. According to figures quoted in a Special Article in the January issue of the Journal there are nearly 400,000 under 20 who have had no polio injections.

This then would indicate that there is a tremendous job to be done by the physicians of the state to achieve total immunization in just this age group.

In line with other phases of the AMA recommendation, many county societies are already cooperating with their city and county health departments to set up joint study committees on the local level to survey the problem of immunization as it exists locally and to implement a program to meet the situation.

Your part in the success of this operation is a big one. Will you accept this responsibility?

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

Medicine - - and Blue Shield - - Accept the Challenge

SELDOM—if ever before—has medicine earned such a "friendly press" as greeted the action of the A.M.A. House of Delegates at its Minneapolis meeting in December, when it resolved that "the A.M.A., the constituent and component medical societies, *as well as physicians everywhere,* expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income" . .

To make such a program possible, the A.M.A. Delegates realistically urged "that physicians agree to accept a level of compensation for medical services rendered to this group which will permit the development of such insurance and prepayment plans at a reduced premium rate."

Thus, American medicine has forthrightly accepted the challenge of the Forand Bill and acknowledged the special needs of our older citizens, many of whom are getting along on extremely modest retirement incomes.

The national association of Blue Shield Plans has responded promptly to the A.M.A. action. Its staff, under the direction of a special committee, is developing a pattern of coverage, payments and subscription rates that can be used by local Blue Shield Plans in developing their local programs for senior citizens.

Each of us will soon have an opportunity to take part in this great professional enterprise. For it will be up to us, as individual physicians, to make good this A.M.A. pledge. We will be called on for a new and crucial demonstration of the ability of our free profession to meet its collective responsibilities by voluntary action in a free society.

County Society Officers Conference

Thursday, March 26

Phoenix Hotel

Lexington

ORGANIZATION SECTION

Speakers from Both Coasts and the Mid-West Featured on Program of Ninth Annual County Society Officers Conference

Third party medicine—a subject of vital concern—will be the topic highlighted at the ninth annual County Society Officers Conference at the Phoenix Hotel in Lexington on Thursday, March 26, according to Robert W. Robertson, M.D., Paducah, KSMA president.



Dr. Howard

Commenting on the program which will be headlined by six well-known speakers from throughout the nation, Doctor Robertson called it one which conscientious leaders in both the county and state societies can not afford to pass up.

A panel on some of the problems developing in third party medicine will make up the morning session of the meeting and will be moderated by Hugh Brenneman, public relations consultant for the Michigan State Medical Society.

Mr. Brenneman, who has been active in the field of communications even prior to his graduation from Alma College in 1936, is a private public relations consultant who also serves the Michigan State Bar Association, the Michigan Association of the Professions, and the Michigan Society of Architects.

"Legislating Medical Care for Our Senior Citizens" will be the topic of the discussion by Ernest B. Howard, M.D., Chicago, assistant executive vice presient of the American Medical Association. He will give special attention to the problems of the aged and will discuss Forand-type legislation.

A 1936 graduate of Boston University Medical School, Doctor Howard has held an executive position with the AMA since 1948. He also holds a Master of Public Health degree from Harvard University. In 1946-47 he headed a health mission sent to Peru by the U. S. Department of State and in recognition of this service received Peru's highest decoration, the Order of Sol.

Leslie Hodson, Chicago, legal counsel for the AMA and recognized authority on anti-trust legislation, will have as his topic, "Laws Applicable to Medical Society Relations with Closed Panel Plans."

"Do Medical Societies Need Physician Policing?" will be the subject of Donald Cass, chairman of the Professional Relations Committee of the 7000-member Los Angeles County Medical Association. He has a wealth of experience to draw on for this talk, since he has been a medical society "policeman" for 20 years.

Doctor Cass, a graduate of Stanford University, is a past president of the California Medical Association. He has served for many years on the councils of the state and county societies and since 1945 has been a delegate to the AMA. He has been chairman of the California delegation for the past five years.

"What's So Funny About Practicing Medicine?" will be the topic discussed by Russell B. Roth, M.D., Erie, Pennsylvania, at the luncheon session. Doctor Roth, vice chairman of the Board of Trustees of the Medical Society of the State of Pennsylvania, is noted for this illustrated presentation, which is both subtle and humorous and has been given nearly 50 times at national, state, and county medical meetings.

A urologist, he graduated from Johns Hopkins School of Medicine in 1939, and is currently chairman of the Federal Medical Services Committee of the AMA and a member of the Council on Medical Services. He is also a past president of the Erie County Medical Society.

The closing session of the meeting will be devoted to a talk by Donald Stubbs, M.D., chairman of the Board of the National Blue Shield Medical Care Plans. Doctor Stubbs, who has long been identified with voluntary health insurance efforts, will discuss these socio-economic problems as they relate to medicine. His subject will be "Blue Shield and American Medicine."

Doctor Stubbs is a graduate of George Washington University School of Medicine in 1932. He is presently a clinical professor of anesthesiology there, chief of anesthesia at Doctor's Hospital and Consultant at the National Institute of Health and Walter Reed Hospital. He is president of the Medical Service of the District of Columbia (Blue Shield).

Picture and biographical information on Leslie Hodson will appear in the March issue, since it did not arrive in time for inclusion in the February Journal.

Will Your Officers be Invited?

If you're one of the county society secretaries who has not yet forwarded his listings of new officers and committeemen to the Headquarters Office, you are requested to do so at your earliest possible convenience.

The importance of getting the names in promptly was stressed by Robert W. Robertson, M.D., KSMA president, who said he was making this urgent request so that these new officers and committee members might receive invitations to the County Society Officers Conference in Lexington on March 26.

Program

Ninth Annual County Society Officers Conference

Phoenix Hotel, Lexington **Thursday, March 26, 1959**

MORNING SESSION

Fireside Room
Robert W. Robertson, M.D., Paducah, President
Kentucky State Medical Association, presiding

9:00 a.m. **Registration**

9:15 a.m. **Coffee Call**

9:40 a.m. **Call to Order and Announcements,** Dr. Robertson
Invocation, Rev. Garland O'Neill, Lexington
Welcome, W. O. Preston, Lexington, President, Fayette County Medical Society
Remarks from the Secretary, Woodford B. Troutman, M.D., Louisville

9:55 a.m. **Panel—Developing Problems in Third Party Medicine**
Introduction of Moderator, Dr. Robertson
Moderator—Hugh W. Brenneman, Lansing, Michigan, public relations counsel, Michigan State Medical Society
"Legislating Medical Care for Our Senior Citizens," Ernest B. Howard, M.D., Chicago, Illinois, assistant executive vice president of the AMA
"Laws Applicable to Medical Society Relations with Closed Panel Plans"—Leslie Hodson, Chicago, Illinois, legal counsel for the AMA

10:55 a.m. **Coffee Break**

11:05 a.m. **"Do Medical Societies Need Physician Policing?,"** Donald Cass, M.D., Hollywood, California, chairman, Professional Relations Committee, Los Angeles County Medical Association
Discussion Period

LUNCHEON SESSION

Public Dining Room Number Three
Robert W. Robertson, M.D., Presiding

12:30 a.m. **"What's So Funny About Practicing Medicine?"** Russell B. Roth, M.D., Erie, Pennsylvania, chairman, Federal Medical Services Committee, AMA

AFTERNOON SESSION

Private Dining Room Number Three
Irvin Abell, Jr., M.D., Louisville, President-Elect
Kentucky State Medical Association, presiding

2:00 p.m. **"Blue Shield and American Medicine,"** Donald Stubbs, M.D., Washington, D. C., chairman, Board of Directors Blue Shield Medical Care Plans

2:40 p.m. **Discussion**

3:00 p.m. **Adjournment**


Dr. Roth


Dr. Cass


Mr. Brenneman


Dr. Stubbs

Heart Symposium in Louisville to Feature 13 Speakers

Thirteen authorities from throughout the U. S. will be featured on the program of the fifth annual symposium on cardiovascular diseases on the Roof Garden of the Brown Hotel in Louisville on Wednesday and Thursday, March 11 and 12.

"The Clinical Spectrum of Coronary Heart Disease" will be the topic of a talk by A. Carlton Ernstene, M.D., Cleveland, Ohio, president-elect of the American Heart Association at the dinner on Wednesday, March 11.

The meeting, which is acceptable for 11 credit hours by the American Academy of General Practice, is sponsored by the Heart Association of Louisville and Jefferson County, Inc., and the University of Louisville School of Medicine. George W. Pedigo, Jr., M.D., Louisville, is symposium chairman.

Nat'l. Rural Health Conference Slated for March 5-7

The 14th National Conference on Rural Health in Wichita, Kan., March 5-7, sponsored by the American Medical Association's Council on Rural Health, will highlight mental health, aging, nutrition, dental health, costs of medical care, and health insurance and their effect on rural residents.

Mitchell B. Denham, M.D., Maysville, chairman of the KSMA associate committee on Rural Health and the Kentucky Rural Health Council, is expected to attend the meeting. All KSMA members who can get away are urged to attend. Among speakers at the meeting, which is expected to be attended by 700 representatives of medicine, farm groups, governmental agencies, and other lay groups, will be Louis M. Orr, M.D., Orlando, Fla., president-elect of the AMA.

"Horizons in Rural Health" will be the conference theme and these horizons will be outlined by F. S. Crockett, M.D., Lafayette, Ind., chairman of the AMA Council. A keynote speaker at the meeting will be Earl L. Butz, Ph.D., dean of agriculture and director of agricultural extension services at Purdue University.

Blue Shield Advisory Commission Appointed by Dr. Robertson

As the result of a recommendation from the Board of Directors of the Kentucky Physicians Mutual, Inc., to the KSMA House of Delegates at its 1958 meeting, a KSMA Advisory Commission to Blue Shield has been appointed by Robert W. Robertson, M.D., Paducah, KSMA president.

The commission will study the possibilities of expanding Blue Shield benefits and will make recommendations on how these additional services can properly be financed on a prepayment basis.

Members appointed to the Advisory Commission are: W. Vinson Pierce, M.D., Covington, chairman; C. Walker Air, M.D., Covington; Harry S. Andrews, M.D., Louisville; Chester M. Blanton, M.D., Paducah; Willard Buttermore, M.D., Corbin; Louis M. Foltz, M.D., Louisville; Hugh Houston, M.D., Murray; Arthur H. Keeney, M.D., Louisville; J. Murray Kinsman, M.D., Louisville.

James T. McClellan, M.D., Lexington; William K. Massie, M.D., Lexington; Alfred O. Miller, M.D., Louisville; Robert A. Orr, M.D., Mayfield; Sam A. Overstreet, M.D., Louisville; Richard R. Slucher, M.D., Louisville; Garnett J. Sweeney, M.D., Liberty; Malcolm D. Thompson, M.D., Louisville; Donald B. Thurber, M.D., Louisville; William R. Willard, M.D., Lexington; and Fred M. Williams, M.D., Louisville.

Doctors Pierce, Air, Andrews, Miller, Slucher, Thompson, and Willard make up the executive committee of the Commission.

AMA News to Publicize Many Resolutions and Reports

A report asking that the "AMA News" give publicity to many resolutions and reports before they are acted upon by the AMA House of Delegates was approved by the House at its interim meeting in Minneapolis, December 2-5.

The recommendation, made in the supplementary report of the Board of Trustees, had as its main objective the promotion of an informed professional and public opinion. In making the suggestion, the Trustees stressed the value of such publicity to the profession as a whole, saying it gives physicians opportunity to learn more about the problems confronting the AMA House of Delegates and to contact their delegates to express their opinions.

The report said in part, "The failure to disseminate the information regarding an important policy matter only stimulates rumor and misrepresentation. In the long run it is to our advantage, as well as the public and profession, to make available, factual, judiciously selected information on matters under consideration as well as on those on which definitive action has already been taken."

Ninth Dist. and KAGP Meet in Maysville, March 25

The KSMA's Ninth Councilor District will hold a joint seminar meeting with the Kentucky Academy of General Practice in the Capri Room of Caproni's Restaurant in Maysville on Wednesday, March 25, according to an announcement from J. M. Stevenson, M.D., Brooksville, Councilor for the Ninth District, and Mitchell B. Denham, M.D., Maysville, KAGP program chairman.

Two speakers from the Cleveland Clinic and two from Ohio State University College of Medicine will participate in the afternoon program which is scheduled to start at 1 p.m. KSMA President Robert W. Robertson, M.D., Paducah, and the deans of Kentucky's two medical schools, Murray Kinsman, M.D., of the University of Louisville, and William R. Willard, M.D., of the University of Kentucky, will present the evening program.

Wives are invited to attend the meeting, which is a seminar for Academy members in the northeastern section of the state. William H. Sewell, M.D., president of the Mason County Medical Society, will welcome those attending the meeting. The afternoon program will be followed by a social hour at

5 p.m. and dinner at 6:30 p.m. After the dinner, Doctors Robertson, Kinsman, and Willard will give their presentations.

Committees Meet to Make Plans for '59 Annual Meeting

As the Journal went to press, R. W. Robertson, M.D., Paducah, KSMA president and chairman of the Committee on Scientific Assembly and Arrangements, announced that plans for the 1959 KSMA Annual Meeting were approaching the final stages.

Presidents of the 13 specialty groups participating in the meeting met in Louisville on January 22 and the Committee on Scientific Assembly and Arrangements was scheduled to meet on February 12.

The scheduling of guest speakers for the annual program was of prime consideration at each meeting, according to Doctor Robertson. Specialty group presidents announced the guest speakers to represent them on the general program of the meeting. Each year featured speakers representing various specialty groups participate in the general session.

"It is anticipated that this year's program will be an excellent—one—and even will rank with the best the Association has presented," Doctor Robertson said.

Blue Shield Completes 10 Years of Service to Kentuckians

On January 1 of this year, J. Vernon Pace, M.D., Paducah, president of the Blue Shield of Kentucky, announced that the Plan had completed ten years of service to the people of the state.

Doctor Pace also stated that the KSMA, sponsor of the Blue Shield Plan, has authorized the appointment of a Blue Shield Advisory Commission to do research on the prepayment needs of the people of Kentucky.

D. Lane Tynes, M.D., executive director of the Plan says: "Both Blue Shield and Blue Cross have only one purpose, to provide protection against the costs of surgical and hospital care at a price which people can afford. We will continue to meet the needs and demands of the public."

Nearly 89,000 Tested in Ky. for Diabetes in '58

According to the latest tally from the Associate Committee on Diabetes, 175 newly proved diabetics were discovered in Kentucky during the 1958 KSMA Diabetes Detection and Education Drive in November.

With all but 22 counties having reported, 88,802 Kentuckians had been tested. Of these, 1137 urine sugars were found positive and 349 proved to be diabetic.

These figures represent returns from 71 Kentucky counties. In the 1957 drive, 83 counties reported only 52,400 tested with 272 proved diabetics and 137 newly proved diabetics.

This was the eighth annual drive conducted by the KSMA in cooperation with the American Diabetes Association. Robert J. Hoffman, M.D., South Fort Mitchell, is chairman of the Associate Committee on Diabetes.

The County Society Officers Conference in Lexington will start at 9:40 a.m. Central Daylight Saving Time.

Dr. Molner to Speak in Louisville at Annual KAGP Meeting

Joseph G. Molner, M.D., Detroit, Michigan, who writes the daily column "To Your Good Health" in the Courier-Journal, will be featured speaker at the eighth annual session of the Kentucky Academy of General Practice on April 22, 23, and 24.

Announcement of the meeting was made by Stuart M. Hunter, M.D., Louisville, who is in charge of arrangements. Charles Bryant, M.D., Louisville, is KAGP president. Elections for 1959-60 will be held during the annual session.

This year's meeting will be held at the Kentucky Hotel for the first time in several years. Full program of the meeting will appear in the March issue of the Journal.

Ky. School Health Council Formed by Five State Groups

The KSMA and four other Kentucky organizations combined forces to form a Kentucky School Health Council at a meeting sponsored by the Association in Louisville on January 8.

Aimed at achieving closer cooperation with public school officials in school health programs, the Council is made up of two representatives from each of the following organizations: The KSMA, the Kentucky Dental Association, the Kentucky Department of Education, the Kentucky State Department of Health, and the Kentucky Parent Teacher's Association.

Carroll L. Witten, M.D., Louisville, chairman of the KSMA School Health Committee, was elected Council chairman. Other officers are Don C. Bale, Kentucky Department of Education, Frankfort, vice chairman; and Judith A. Stout, M.D., State Department of Health, Louisville, secretary.

A committee to study and recommend revision in the school health code and school health forms and to cooperate in setting up work shops on school health was appointed by Doctor Witten.

P. O. Ruling on Mailing Rx's Announced by Postmaster

A ruling from the U. S. Post Office Department regarding the mailing of bottles containing medicine having labels carrying prescriptions attached to them, has been announced by J. D. Scholtz, postmaster of the Louisville Post Office.

Under the ruling, prescriptions having *handwritten* or *typed* instructions as to use attached to the bottle are subject to a first class rate of postage. If the label is not attached to the bottle, but is included as a loose enclosure, the rates of postage for combination mailings of mixed classes of mail are applicable.

Medicines bearing *printed* labels with directions for use are acceptable at the third or fourth class rates of postage. If you have any questions on this matter, contact your local post office.

Digest of Minutes of The KSMA Council Meeting on December 11, 1958*

The Chairman of the Council called the meeting to order, thanked the members for their attendance along with a note of welcome for the guests and requested Mr. Grogan to introduce William E. Rudd, the new Executive Assistant of the Association.

Minutes of the September 22, 24 and 25 Council meetings were adopted as mailed. The President reported on his attendance at the December 4, 1958 Rural Health Conference and read a proposed list of twenty-one members to serve on an Advisory Commission to Blue Shield from KSMA.

The delegates to the interim meeting of the AMA held in Minneapolis gave a full report on the main issues and objectives discussed at this meeting including some of the problems that medicine is facing and the providing of active leadership in solving this issue. The Council authorized the Executive Secretary to send a letter of appreciation to Vincent Askey, M.D., Los Angeles, Speaker of the AMA House of Delegates, for his cooperation in securing the passage of a commemorative stamp for Ephraim McDowell-Jane Todd Crawford 150th anniversary of the first successful oophorectomy. The Council accepted a recommendation that a four man committee be appointed and that $1000 be set aside to defray expenses of KSMA committee chairmen attending national meetings of special interest. This committee would "screen" the meetings to determine if KSMA should be represented.

The Headquarters Office report was presented by the Secretary, who called particular attention to the second annual dinner for Kentucky's congressmen and senators to be held in Washington, February 26, 1959.

Comments were heard from the Commissioner of Health who also read a recommendation by the AMA in regard to poliomyelitis inoculation. This program was discussed and the Council approved the recommendations of the AMA House of Delegates and instructed the Headquarters Office to mail the recommendation and steps to be taken to all county medical societies.

The Chairman called the attention of the Council to the stand taken recently by Jefferson and Taylor Counties in admonishing a member of their respective societies. The Council then authorized Headquarters Office to send a letter to these two societies commending them on their actions.

Executive Committee Referrals

It was agreed by the Council that the County Society Officers Conference be held in Owensboro in 1960 on a trial basis for that year only.

Garnett J. Sweeney, M.D., Liberty, Chairman of the Council, stated several difficulties had been encountered in securing participants and that it had been necessary to revise the recommendations which were approved November 6 by the Executive Committee. After discussion, the Council approved the following program and participants:

(1) Ernest B. Howard, M.D., Assistant Executive President of the AMA, who will present an overall review on Forand type legislation,

(2) Donald Cass, M.D., Chairman of the Professional Relations Committee of Los Angeles County Medical Association, who will give a talk on medical societies policing themselves,

(3) Leslie Hodson, anti-trust lawyer for the AMA, who will participate in a panel discussion on third party medicine with Hugh W. Brenneman of the Michigan State Medical Asscication and the Michigan Bar Association serving as moderator,

(4) A luncheon session with Russell Roth, M.D., presenting his illustrated lecture on medical public relations,

(5) Final presentation to be by Donald Stubbs, M.D., of the National Blue Shield Commission.

The appeal of Allyn F. Judd, M.D., Whitesburg, was discussed at length and was not accepted. The Council approved the holding of an open meeting in the summer, to which meeting all KSMA members will be invited.

Carl Cooper, Jr., M.D., Bedford, and Russell E. Teague, M.D., Commissioner of Health, Louisville, presented information on the formation of the Kentucky Health Council along with its objectives. It was stated this body will be a coordinating body with an aim of providing means for joint planning, for all agencies concerned with health, to study these needs, and to arouse public interest in these needs. It was pointed out that the Kentucky Health Council is not a branch of the National Health Council and with unity of several organizations the health interest of our Commonwealth could best be served. After a thorough and lengthy discussion the Council decided to appoint a committee to study the objectives and other matters relating to the Kentucky Health Council and to report their findings to the Council at its next meeting. Doctor Cooper, Chairman, Branham B. Baughman, M.D., Frankfort and Walter L. O'Nan, M.D., Henderson, were then named to this committee.

Edward B. Mersch, M.D., Covington, Chairman of the KSMA Committee on Third Party Medicine stated his committee had no definite announcement on the solution to the problem due to the complexity and wide scope involved; that he and the committee were hoping to come up with an acceptable plan but it could take considerable time.

Instructions were given to the Committee on Third Party Medicine to secure information, when necessary, from local sources in problems relating to physicians in practice, and to so use this information as a basis in determining if the physician meets the requirements in the area for the type of practice applied for.

Permission was granted by the Council to the KSMA President to call a special session of the KSMA House of Delegates if circumstances so warrant.

**As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the December 11 meeting of the KSMA Council.*

Legislative Program To Be Expanded

Adopting the KSMA Committee on Legislation's recommendations that the Legislative program on the state and national levels be expanded, the Council then approved the reimbursement of legislative key men for emergency phone calls if the key men so elected to be reimbursed. It was also decided by the Council to furnish each legislator, both on the state and national level, a subscription to the "AMA News."

The Council voted to re-introduce the Quick Cremation Bill into the 1960 State Legislature.

Robert D. Shepard, M.D., and Robert B. Warfield, M.D., both of Lexington, were appointed to serve on the Legislative Committee as representatives from Fayette County. The Council then went on record to recommend asking all county medical societies to entertain their respective legislators and also invite them to councilor district meetings along with Mr. Grogan, Director of Field Services for KSMA.

In connection with the change in the fee schedule for the Veterans Hometown Medical Care Program, it was adopted that any changes in the fee schedule be left to the Committee on Federal Medical Services.

Insurance Blank Forms

The Council authorized the purchase of two copies of the film, "The Medicine Man." These copies will be used by the State Department of Health in its lending library wtih full credit going to KSMA. The short form insurance claim blank which has been revised was adopted by the Council and will soon be made available.

It was voted that the editor of "Kentucky Business," which is published by the Kentucky Chamber of Commerce, be written a letter of commendation for the articles on the Rural Kentucky Medical Scholarship Fund and Great Medicine in the December, 1958 issue. There being no further business the meeting was adjourned at 3:10 P.M.

Dr. Kornhauser of U of L Dies at 71

Dr. Sidney I. Kornhauser, a long-time professor of anatomy at the University of Louisville Medical School and one of the most beloved members of the faculty died on New Year's day in Louisville. He had suffered a heart attack about 12 years ago and had been under a doctor's care, but had not been ill recently.

Until last June, he had been chairman of the medical school's department of anatomy. At that time, he continued as professor and took over the additional duties of director of admissions. In about three weeks, he was to have quit teaching entirely.

He received his Ph.D. at Harvard University in 1912. He came to the U of L in 1922 as chairman of the department of anatomy after teaching at George Washington University, Harvard, Northwestern and Denison Universities. He was an honorary member of the Jefferson County Medical Society, Alpha Omega Alpha, and Phi Delta Epsilon. He was also chairman of the U of L's library committee. For several years he headed the Kentucky selection committee for Rhodes Scholarships to Oxford University in England.

Senior Day Set for March 16 in Louisville

The annual Senior Day—for this year's graduates of the University of Louisville School of Medicine —is scheduled for Monday, March 16, according to Nathaniel L. Bosworth, M.D., Lexington, chairman of the KSMA Senior Day Committee.

Aimed at helping graduates make an easier transition from the class room to the reality of practice, the day is sponsored by the KSMA, with the cooperation of the Jefferson County Medical Society and the University of Louisville School of Medicine. Sessions will be held at the Kentucky Hotel and Rankin Amphitheatre.

Featured speaker at the dinner will be Dr. Carl S. Winters, pastor of the First Baptist Church of Oak Park, Illinois. Doctor Winters appears through the courtesy of the General Motors Corporation. More information on the Senior Day program will appear in the March issue.

Bids to be Asked for Phase 3 of UK Medical Center

Bids will be asked this spring for the third phase of construction on the U of K's $26 million medical center, according to Frank D. Peterson, U of K vice president for business administration who said they would probably be taken the latter part of March.

Dr. Peterson said that the awarding of the contract and start of construction should take place by early May. The third phase of the project includes a general hospital, a minimal care wing, and an outpatient clinical facility.

The first two phases of the center—the medical sciences building and the power plant—are under construction. R. K. Noback, M.D., the medical center's assistant dean, said the medical-sciences building is scheduled for completion late next fall.

Dr. Pedigo Is President-Elect Of Jefferson Co. Soc.

George W. Pedigo, Jr., associate editor of the Journal of the KSMA and vice speaker of the House of Delegates, was chosen president-elect of the Jefferson County Medical Society at a meeting in Louisville in January.

Doctor Pedigo, an internist, will take over as head of the 800-member society next January, succeeding Foster D. Coleman, M.D., who is now president. He has been secretary and treasurer of the society and is president-elect of the Kentucky Society of Internal Medicine.

Other officers elected at the annual meeting are: Daniel G. Costigan, first vice president; Roy A. Martin, M.D., second vice president; Maurice T. Fliegelman, M.D., secretary; Max P. Jones, M.D., treasurer; and J. Thomas Giannini, M.D., and Thomas M. Marshall, M.D., judicial-council members.

Virgil Kinnaird, M.D., Dies in Lancaster on Jan. 11

Virgil Gibney Kinnaird, M.D., who had served the KSMA as a councilor for 24 years prior to 1946, died at his home in Lancaster from a heart attack on Sunday, January 11.

Doctor Kinnaird, who had practiced medicine in his home town (Lancaster) for 40 years, was the recipient of Garrard County's "Outstanding Citizen" Award in 1956. For a time during World War II, he was the only physician serving Garrard County.

He was the father of David W. Kinnaird, M.D., Louisville. Doctor Kinnaird attended the University of Louisville School of Medicine and later transferred to the Jefferson Medical College in Philadelphia graduating in 1913. He was a trustee for the Kentucky School for the Deaf, Danville, and was a member of the board of the Centre College Alumni Association. It was under his direction that the Garrard Memorial Hospital was built in 1949.

Louisville M.D.'s on Program of ACS in St. Louis

Five Louisville physicians are scheduled to take part in the program of the sectional meeting of the American College of Surgeons in St. Louis, March 9 through 12. A joint nurses program is an annual feature of the four-day meeting.

About 3,500 surgeons, nurses, and related medical personnel are expected to attend. The nurses will hold their sessions separately and simultaneously with the surgical sessions. The meeting is designed to inform the medical profession at large about developments in surgery and to focus attention on new ways of handling problems encountered in daily practice.

Hugh Lynn, M.D., and Rudolf Noer, M.D., will be on the sectional program on general surgery on Thursday, March 12. They will collaborate in a cine clinic on "Duodenal Obstruction in Infancy" and Doctor Lynn will present "Congenital Malformations of the Colon and Anus."

On Monday, March 9, Laman A. Gray, M.D., will speak on "Conservative vs. Definitive Approach to Tumors of the Uterus" and Rudy F. Vogt, M.D., on "Conservative vs. Radical Surgery with Tumors of the Ovary." Robert Lich, Jr., M.D., Louisville, will preside at a session on urology on Wednesday, March 11.

PG Pediatric Course to Start on April 14 in Louisville

The annual Pediatric Postgraduate Course, sponsored by the University of Louisville Medical School Department of Pediatrics, will be held each Tuesday morning from April 14 through June 2 in the amphitheatre of Children's Hospital, Louisville.

Under the direction of A. J. Steigman, M.D., chairman of the Department of Pediatrics, the course will be given from 9:30 a.m. to 12:30 p.m. each Tuesday.

The complete program of the course will be carried in the March issue of the Journal. All KSMA members are invited to participate.

STUDENT AMA

In the past few months those of us at U. of L. Medical School have been most gratified to see an upsurge in the number and quality of internships available in the city. Several of the private hospitals have reinstituted internships which had been lost in the past. Those hospitals with internship programs already in operation have shown our senior class evidence of continued progress in the direction of better training for the intern.

During a recent Chicago meeting of the SAMA Standing Committee on Graduate Education, it was brought to the mind of your correspondent that the problems faced by the students and hospitals in Louisville are in no way unique from those facing students and hospitals in all other parts of the country. It was remarked by Dr. John C. Nunemaker (AMA Council on Medical Education and Hospitals) that more and more the hospitals of the country are coming to realize that an internship program, if it is to be successful, must be more than just a year of "pledgeship" prior to entry into the full fraternity of medicine.

We are lucky in this area in that those internships which are being presented by our hospitals seem to have as their objective a truly educational experience for the new physician.

Although the ultimate choice of internships must be decided by the individual student on the basis of his needs and projected plans for the future, the availability of internships of high caliber in the immediate area help him to a great extent in his decision by giving him criteria by which he may judge other hospitals.

This new interest in internships by the Louisville hospitals is indicative of the growing emphasis which is being placed on postgraduate medical education with the hospital serving as a focal point in such programs. As the hospitals strive to improve their own internship programs they must necessarily compete with each other for the prospective intern, and this competition should lead only to better training not only for the new but also for the established physician, eventually resulting in a better medical community for the student, intern and the practitioner.

We wish all of the hospitals the best of luck in obtaining their desired interns and hope that they will continue to strive for better medical education on all levels.

Neville Caudill, President
U. of L. Chapter, SAMA

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1959 Annual Meeting — Kentucky State Medical Association

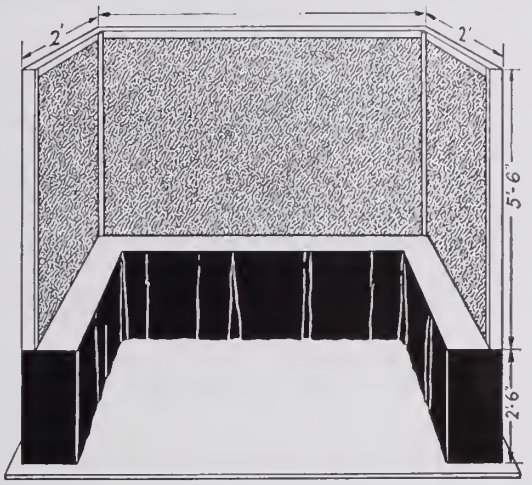
Columbia Auditorium — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

EVERETT L. PIRKEY, M.D., Chairman
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

Applications for space should be received before July 1, 1959

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

Dept. of Mental Health Reports More Releases in '57-'58

The Kentucky Department of Mental Health released 26 per cent more patients from its mental hospitals in fiscal year 1957-58, than in the previous year, according to an announcement from H. L. McPheeters, M.D., Department Commissioner.

In September, he said the census in Kentucky four mental hospitals dipped below 7,000 to set a seven year record. There were 6,964 patients in the four hospitals on September 30, compared with a high of 7,748 in March, 1955.

Doctor McPheeters, in his annual report to Governor A. B. Chandler, mentioned the increased emphasis on freedom for mental patients—"freedom for its therapeutic value of teaching responsibility. During the past year an alcoholic rehabilitation unit opened at Western State, Hopkinsville, and new buildings were opened at Eastern State Hospital, Lexington, and at Kentucky State Hospital in Danville.

Dr. Sparks to Address GP's

"Third Party and You" is the topic of the talk which Clyde C. Sparks, M.D., Ashland, speaker of the KSMA House of Delegates, will give at a meeting of the Jefferson County Chapter of the Kentucky Academy of General Practice in Louisville on February 12.

Carroll L. Witten, M.D., president of the Jefferson County Chapter of the KAGP, announced that the meeting would be at the Medical Arts Building and would begin with a social hour at 6:15 p.m., followed by a dinner at 7 p.m.

Members Urged to Vote in May

All KSMA members are reminded that in order to vote in the *May 26* primary they should register to vote not later than *March 28*, by Thomas Leonard, M.D. Frankford, chairman of the KSMA Legislative Committee for State Affairs.

Doctor Leonard urged all Kentuckians to take an interest in the elections and to take advantage of the voting privilege by studying the candidates and the issues and going to the polls in May.

Dickinson Retires from AMA

Frank G. Dickinson, Ph.D., Evanston, Ill., has retired as director of the AMA Bureau of Medical Economic Research, according to an announcement from F. J. L. Blasingame, M.D., executive vice president of the American Medical Association.

Doctor Dickinson, who joined the AMA staff in 1946 after teaching economics at the University of Illinois for 25 years, said he plans to do consulting work and to conduct research under the sponsorship of a research foundation. He originated the Dickinson Football Rating System, his hobby from 1924 to 1940.

Ky. Ob. - Gyn. Society Plans Meet

The Kentucky Obstetrical and Gynecological Society will meet May 7, 8, and 9 at Kentucky Dam Village State Park in Gilbertsville, according to Douglas M. Haynes, M.D., secretary-treasurer of the Society, who is in charge of the program for the meeting.

Dr. Steigman in Cuba on Jan. 1

Alex J. Steigman, M.D., chairman of the department of pediatrics of the University of Louisville School of Medicine, and his wife were vacationing at Varadero Beach, about 114 miles from Havana, when the Batista Government fell.

When the rebel radio made the announcement of the fall of the old government and announced a general strike, Doctor Steigman said, "It was really very peaceful and orderly. There was no call for blood or the surrender of any heads." He said, "there was a great hush all over the city. The people were very quiet and very sober. The Cubans are a gay, but responsible people." He and his wife were among 90 flown out of Cuba on a special plane on January 4.

Two from U of L Speak in Indiana

Two members of the University of Louisville Medical School faculty were featured speakers at recent meetings of the Vanderburgh (Indiana) County Medical Society. Eugene H. Conner, M.D., professor of anesthesia at the U of L spoke on "Preparation of the Patient for Anesthesia" at the November meeting and Rex O. McMorris, M.D., chairman of the department of Physical Medicine and Rehabilitation at the U of L and director of the Evansville Rehabilitation Center talked on "Rehabilitation in Medicine" at the December meeting.

Anticoagulant ID Cards Available

The Kentucky Heart Association has announced that it now has a supply of Anticoagulant Identification Cards available for distribution to Kentucky Physicians.

The cards afford protection to the patient on long-term anticoagulant therapy. In case of accident that causes bleeding the patient may require an antidote to the anticoagulant. It should be useful in the case of emergency treatment, medical care away from home, or dental surgery. The cards are free and any physician in the state may get a free supply by writing the Kentucky Heart Association, 401 Speed Building, Louisville 2, Ky.

AMEF Receives $348,658

Checks totalling $348,658 were accepted for the American Medical Education Foundation by George F. Lull, M.D., president of its Board of Directors at the AMA Clinical meeting in Minneapolis.

Largest donations were $150,305, representing a gift from every member of the California Medical Association, and $100,000 from the American Medical Association. Other gifts included, $35,110 from Indiana, $19,608 from New York; $25,000 from New Jersey; $9,977 from Utah; and $8,657 from Arizona. The checks brought the year's total to $940,000.



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*A Symposium on the Pharmacologic Effects of Dartal on the Liver, Chicago, Searle Research Laboratories, Feb. 7, 1958.

U of L Announces Faculty Changes

Recent changes in the faculty of the University of Louisville Medical School were announced following a meeting of the University's Board of Trustees. Dr. Pinghui Victor Liu was promoted to assistant professor of microbiology. Ellis Duncan, M.D., resigned as associate professor of surgery; Luis Stamer, M.D., was appointed assistant professor of physical medicine and rehabilitation; Richard C. Proplesch, M.D., instructor in medicine; and Charles O. Bruce, M.D., instructor in ophthalmology; and Miss Barbara Hays, instructor in medical technology.

Ky. Surgeons to Meet in May

The Kentucky Surgical Society and the Indiana and Kentucky Chapters of the American College of Surgeons will meet jointly at the French Lick Sheraton, French Lick, Indiana, on May 15 and 16, according to an announcement from Melvin Bernhard, M.D., Louisville, secretary-treasurer of the Kentucky Surgical Society, and W. T. Rumage, M.D., Louisville, program chairman for the Kentucky Chapter, American College of Surgeons.

U of L Biochemist Receives Grant

Robert S. Levy, biochemist at the University of Louisville School of Medicine, recently received a grant of $10,500 from the National Science Foundation to continue his studies on atherosclerosis.

New Orleans Assembly, March 2

The New Orleans Graduate Medical Assembly will hold its twenty-second annual meeting on March 2-5 at the Roosevelt Hotel in New Orleans. A clinical tour of Mexico will follow the Assembly with flights leaving New Orleans for Mexico City on March 6.

Eighteen guest speakers will participate in the Assembly program. The tour will include medical programs and visits to Xochimilco, Taxco, Cuernavaca, Acapulco and San Jose Purua, with return to New Orleans on March 21. Announcement of the meeting and the 16th annual clinical tour was made by Maurice E. St. Martin, M.D., Assembly secretary.

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KHA Moves Office to Lexington

The Kentucky Hospital Association moved its headquarters office from Louisville to Lexington on January 15, according to Wade Mountz, president-elect of the association and administrator of Norton Memorial Infirmary. For seven years the office has been in the Sheraton Hotel in Louisville with Mrs. Elizabeth Simmerman as part-time executive secretary. Mr. Mountz said the move was being made since Lexington is more centrally located and it would make transportation from Cincinnati more convenient for Mrs. Simmerman. The group was founded in Louisville 30 years ago.

Pathologists Elect 1959 Officers

R. J. Ritterhoff, M.D., Covington, was elected president of the Kentucky Society of Pathologists at a meeting at the Lexington Clinic, Lexington. He succeeds J. T. McClellan, M.D., Lexington, who presided during 1958. Other officers are John D. Allen, M.D., Louisville, president-elect; and H. Davis Chipps, M.D., Lexington, secretary-treasurer. Doctor McClellan is assemblyman to the College of American Pathologists and Doctor Chipps is councilman to the American Society of Clinical Pathologists.

Guest lecturer at the meeting was T. B. Magath, head of the department of Clinical Pathology, Mayo Clinic, Rochester, Minn. His subject was "The Echinococcus Problem."

Attend Conference on Gifted Child

Representing the medical profession at a recent one-day conference in Louisville on "Education for Gifted Children" were Everett L. Pirkey, M.D., of the University of Louisville's Department of Radiology; and Richardson K. Noback, M.D., assistant dean of the University of Kentucky Medical Center, and Bobbie R. Grogan, M.D., of the KSMA headquarters office. Three hundred people attended the conference which was sponsored by the State Department of Education. Experts on child psychology were featured on the program.

Pediatrician on Health Dept. Staff

R. Lee Walton, M.D., a former instructor at Yale University Medical School, has been appointed to the newly created position of pediatric consultant in the Bureau of Maternal and Child Health Department of the State Department of Health, according to Russell E. Teague, M.D., Commissioner of Health.

A graduate of Harvard Medical School in 1949, Doctor Walton will be on the faculty of the new University of Kentucky Medical School, as well as serving in the health department post. He interned at Rhode Island Hospital, Providence, and took specialized training at Syracuse University in New York. At Syracuse he was also acting assistant to William R. Willard, M.D., then dean at Syracuse and now dean of the U of K Medical School. For the past two years he has been in private practice in Stratford, Conn.

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(Continued from page 193)

was the report of the Committee to study the American Medical Association objectives and basic program. As you will recall, at the last meeting of the House of Delegates of the AMA the House instructed the Board of Trustees to conduct a survey of the physicians of the United States reviewing the basic objectives and program of the AMA. The questionnaire was sent to several thousand physicians and the results of the questionnaire were reviewed by this committee. We think it is important to say in summarizing the results of this poll, that the overwhelming number of doctors that responded to this poll believe that one of the very important functions of the AMA was active participation in the socio-economic problems of this country in regard to medicine. The entire report is available for any member who wishes to write to the headquarters of the AMA for it. This report, incidentally, is 65 pages long and quite comprehensive. Many of you, we think, would find it very interesting.

Shortly before adjournment of the final session of the House of Delegates Thursday, December 4, your delegates requested and were granted unanimous consent by the House to introduce a resolution entitled: "Request for Memorial Stamp Commemorating the 150th Anniversary of the First Successful Oophorectomy." A copy of this resolution follows.

Resolution

Introduced by: W. Vinson Pierce, M.D., and Robert C. Long, M.D., Kentucky Delegates

Subject: Request for Memorial Stamp Commemorating the 150th Anniversary of the First Successful Oophorectomy

Whereas, Dr. Ephraim McDowell on December 25, 1809 at Danville, Kentucky performed on Jane Todd Crawford the first successful oophorectomy on record, and

Whereas, It has been called to the attention of the Kentucky State Medical Association that if the House of Delegates of the American Medical Association will go on record requesting the issuance by the Post Office Department of a commemorative stamp in 1959 memorializing the above medical milestone; the Post Office Department will give favorable consideration to the issuance of such a stamp, therefore be it

Resolved, That this House of Delegates go on record as approving such a stamp and that it respectfully request the Post Office Department to issue an Ephraim McDowell—Jane Todd Crawford Memorial Stamp commemorating the 150th anniversary of this world-famous operation.

We are happy to report that this resolution passed the House without reference to committee.

In conclusion, we, your representatives to the American Medical Association, would like to express our thanks to our Executive Secretary, Mr. Joe Sanford, who is extremely valuable in many ways. The work of your delegates and alternate delegates is made immeasurably easier by the overall know-how of Mr. Sanford. The presence of our alternate delegate, Doctor George Archer, has been extremely helpful especially in the field of third party problems to which he so ably testified at reference committee.

PERTINENT PARAGRAPHS

The Institute of Industrial Health, University of Cincinnati, is offering graduate training for professional personnel other than physicians in the field of environmental hygiene. The professional training is provided for graduates of approved schools of engineering or science. A three-year course leading to the degree of Doctor of Science in Industrial Health devotes two years to intensive academic study and a third to the preparation of a thesis (additional practical work may be required as indicated).

To stimulate interest in the field of physical medicine and rehabilitation, the American Congress of Physical Medicine and Rehabilitation is sponsoring its sixth annual Essay Award of $200 for an essay on any subject relating to the field, written by interns, residents, and graduate students. The Congress also sponsors the Bernard Baruch Essay Award which is given to a medical student for an essay on physical medicine and rehabilitation. Prize is $100. Manuscripts must be in the office of the American Congress of Physical Medicine and Rehabilitation, 30 N. Michigan Ave., Chicago 2, Ill., not later than March 2, 1959.

The average family doctor today is a well-established physician in his forties who treats about 26 patients a day and spends more than eight hours a day on home and office calls, according to the Health Information Foundation. In its monthly statistical bulletin the Foundation released preliminary findings from a survey made in cooperation with the University of Chicago's National Opinion Research Center. Four out of five persons interviewed by the N.O.R.C. said they had a family physician to whom they turned regularly when they were sick. Most patients "reported a very good opinion of the abilities of their family physicians, reflecting a confidence that is certainly related to success in patient care."

The first comprehensive directory and description of blood facilities and services ever compiled in this country was released recently by the Joint Blood Council, a nonprofit national organization with headquarters in Washington, D. C. It shows the location of facilities, the extent of their operations, how they are organized, what services they offer and other information of importance to physicians, hospitals, and others. Copies may be obtained at $1.50 a copy from Joint Blood Council headquarters, 1832 M St., N. W., Washington 6, D. C.

The Aero Medical Association, in cooperation with the Library of Congress, has completed arrangements to publish a comprehensive annotated bibliography of aviation medical literature for 1953. According to an announcement from Brigadier General M. S. White, USAF (MC), Washington, D. C., president of the society, the volume will be off the press early in January, 1959.

In Memoriam

EDWARD C. BARLOW, M.D.
Georgetown
1876 - 1958

Edward Calistis Barlow, M.D., Georgetown, a retired physician who had limited his practice to the eye, ear, nose and throat, died on November 17 after an illness of 3½ months.

A native of Georgetown, he graduated from the Pultie Homeopathic Medical School in 1901 after attending Georgetown College and the University of Cincinnati. He was a veteran of the Spanish American War and served as a major in World War I.

DANIEL R. BOTKIN, M.D.
Louisville
1882-1959

Daniel R. Botkin, M.D., died at St. Anthony Hospital in Louisville on January 6. He had practiced at Hazard and Berea 32 years before opening his Louisville office 16 years ago.

A native of Laurel County, Doctor Botkin was a graduate of the University of Kentucky and the University of Louisville Medical School in 1911. Doctor Botkin was a general practitioner.

DAVID W. DODD, M.D.
Louisville
1892-1959

David W. Dodd, M.D., assistant chief medical officer at the Veterans Administration Hospital in Louisville, died of cancer at Norton Memorial Infirmary on January 18.

A 1917 graduate of the University of Louisville Medical School, Doctor Dodd joined the VA in 1921 after serving in World War I as a lieutenant and was in the Army Medical Corps as a major in World War II, under the VA. He had been in his present position since 1946 and had also served at VA Hospitals at Lexington and in Murfreesboro, Tenn.

THOMAS E. GOSNELL, M.D.
Louisville
1869-1959

Thomas E. Gosnell, M.D., the University of Louisville Medical School's oldest almunus, died on January 8 at the age of 99.

Doctor Gosnell graduated from the University of Louisville Medical School in 1886 and practiced medicine for 60 years in Louisville. He was top man in his class of about 75. He celebrated his birthday at Ann's Rest Home in Louisville on December 3, where he had been staying since wrenching his back in November. Doctor Gosnell was a native of Leitchfield.

R. M. MASON, M.D.
Murray
1887-1959

R. M. Mason, M.D., who practiced surgery in Murray for more than 40 years, died of a heart attack on January 14.

Doctor Mason was stricken in Murray General Hospital while preparing to perform a major operation. He had been in ill health for several years and had closed his office for a time, resuming practice only recently. Doctor Mason, a graduate of Vanderbilt University School of Medicine in 1912, and his brother the late Will Mason, M.D., established Murray General Hospital.

H. E. MARTIN, M.D.
Lafayette
1882-1959

Hallie E. Martin, M.D., who had served Christian Countians as a general practitioner for 33 years, died at the home of his daughter in Hopkinsville on January 18.

Doctor Martin was a graduate of St. Louis College of Physicians and Surgeons in 1918. He began his medical career in Whitthorn, Tennessee. He had maintained his office at Lafayette on a part-time basis the past two years. Doctor Martin also had a part-time office in Bumpus Mills, Tennessee.

ELMER S. MAXWELL, M.D.
Lexington
1888-1959

Elmer S. Maxwell, M.D., Kentucky's first clinical pathologist outside of Louisville, died on January 9 from a stroke two days after he retired from active practice. He was 70.

A native of Hood County, Texas, Doctor Maxwell helped organize the Lexington Clinic and was a former president of the Fayette County Medical Society. He graduated from the medical department of Vanderbilt University in 1913 and at one time taught at the University of Louisville.

ROBERT GLENN TOWNSEND, M.D.
Grayson
1903-1958

Robert Glenn Townsend, M.D., died at Stovall Hospital in Grayson on December 19 following a heart attack. He had been associated with J. Watts Stovall, M.D., in the operation of the hospital for the past ten years.

Doctor Townsend was a native of Robinson County, North Carolina. He received his M.D. degree from the Tulane University School of Medicine in 1927. He was active in church and civic affairs in Grayson and was co-owner of the Stovall hospital.

County Society Reports

McCracken

The McCracken County Medical Society held its monthly meeting on November 19 at Boswell's Restaurant with Burton Haley, M.D., Paducah, presiding.

Featured on the program of the meeting was a talk by Mr. Charles Hancock, Investigations Narcotics Control Division, State Department of Health. His talk was followed by a discussion period.

Samuel L. French, M.D., Paducah, informed members of the changes in the National Foundation supported by the March of Dimes. He pointed out that the new foundation would now cover such medical problems as arthritis, virus infections, and birth defects, as well as polio. A motion was made and passed not to endorse the Foundation locally at this time and that the matter be filed until further recommendations are made. Vernon D. Pettit, M.D., Paducah, is secretary of the Society.

McCracken

Walker C. Turner, M.D., Paducah, has been elected by the members of the McCracken County Medical Society to serve as the organization's president during 1959.

Other administrative officers elected are B. A. Washburn, M.D., Paducah, vice president; and Vernon D. Pettit, M.D., Paducah, secretary. Composing the executive committee are: Rex Holland, M.D., M. W. Fowler, M.D., three year terms; R. W. Robertson, M.D., and Leon Higdon, M.D., two years; and J. B. Spalding, M.D., and Eugene Blake, M.D., one year.

Errett Pace, M.D., chairman, Eugene Blake, M.D., and C. P. Orr, M.D., were elected to one, two, and three-year terms respectively on the board of censures. Walt Johnson, M.D., Doctor Turner, and Doctor Higdon were named to terms of the same length as delegates to the KSMA House of Delegates.

Mercer

E. H. John, M.D., Harrodsburg, was elected president of the Mercer County Medical Society at its annual business meeting in January. He succeeds George Ballard, Harrodsburg.

Other officers elected to serve the society during the coming year are T. C. VanArsdall, vice president and C. B. VanArsdall, Jr., secretary-treasurer, both of Harrodsburg. Elected as censors for the year are: George Ballard, M.D., James Keightley, M.D., and T. C. VanArsdall, M.D., Harrodsburg.

T. O. Meredith, M.D., was re-elected delegate to the KSMA and Doctor Keightley was named alternate delegate.

Nelson

John J. Sonne, M.D., Bardstown, has been elected president of the Nelson County Medical Society and president of the staff of Flaget Memorial Hospital for 1959. Doctor Sonne succeeds Charles B. Spalding, M.D.

A. D. Steely, M.D., Bardstown, was elected vice president and Charles B. Spalding, M.D., was elected secretary-treasurer of both groups.

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NEWS ITEMS

A farewell dinner was given for **Benton B. Holt, M.D.**, by his friends and associates before he left Ashland to accept a position in Chattanooga, Tennessee. Doctor Holt, a pathologist, was treasurer of the Boyd County Medical Society and had served as director of laboratories at Kings' Daughters, Our Lady of Bellfonte, and Lawrence County General Hospitals.

G. T. Hamm, M.D., who had practiced in Corinth for the past three years, has moved to Melrose, Mass.

Doctor and Mrs. D. M. Fields, pioneer residents of Cumberland, celebrated their golden wedding anniversary on Christmas day. Doctor Fields, who is now 80, settled in Cumberland 51 years ago, shortly after his graduation from the University of Louisville Medical School. He was honored by the civic clubs of Cumberland three years ago on the anniversary of his 47th year of service to his community.

Everett S. Coleman, M.D., a 1955 graduate of the University of Louisville School of Medicine, has started general practice in Sacramento. He took his internship training at the U. S. Naval Hospital in Portsmouth, Va., and was in the submarine service of the U. S. Navy stationed at New London, Connecticut. before coming to Sacramento.

Foster D. Coleman, M.D., has announced that **Lloyd G. Yopp, M.D.**, has become associated with him in the practice of internal medicine. A native of Paducah, Doctor Yopp graduated from the University of Louisville School of Medicine in 1952. He interned at St. Joseph Infirmary in Louisville and took 3½ years of residency training at Henry Ford Hospital in Detroit. Doctor Coleman served two years in the U. S. Navy.

Charles Oldham Bruce, Jr., M.D., a native of New Castle, has become associated with Arthur Keeney, M.D., and Edward Shrader, M.D., in Louisville for the practice of ophthalmology. Prior to coming to Louisville he served seven years in the Army Medical Corps as a major. Following his first tour of duty in the medical corps from 1946-48 he was in general practice in New Castle. Doctor Bruce interned at St. Joseph Infirmary in Louisville after his graduation from the University of Louisville School of Medicine in 1944. He took his residency at Walter Reed Army Hospital from 1952-55.

John J. Untereker, M.D., a 1953 graduate of the University of Louisville Medical School, has been named director of medical service of New York City's Institute for the Crippled and Disabled. Before he entered medicine, Doctor Untereker was a physical therapist. He was head of the polio clinic at General Hospital for a time and was the first president of the Kentucky Chapter of the American Physiotherapy Association.

Walter Leroy Wilson, M.D., has opened an office for the general practice of medicine in Lyndon. A native of Indiana, he graduated from the University of Louisville School of Medicine in 1957. Doctor Wilson took his internship training at St. Joseph Infirmary in Louisville.

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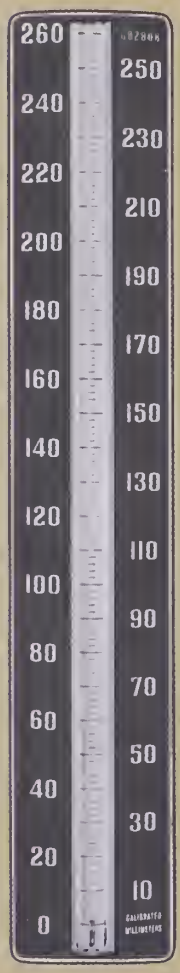
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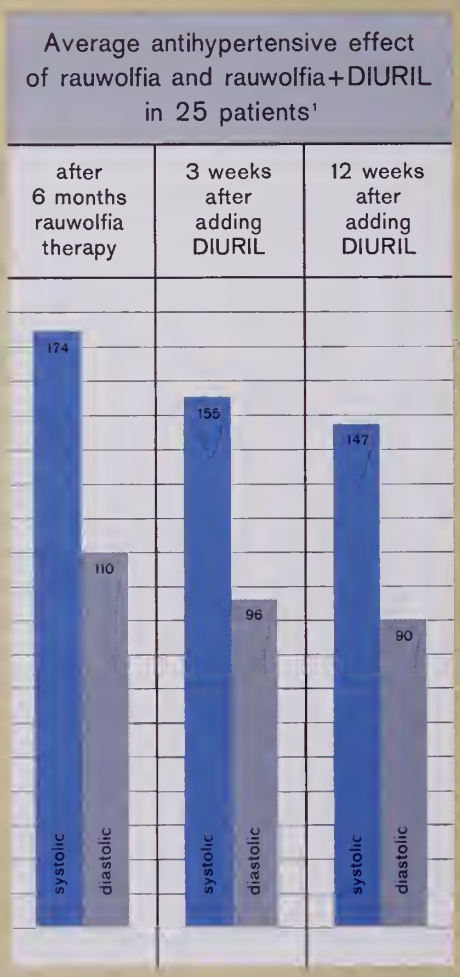
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> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

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Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

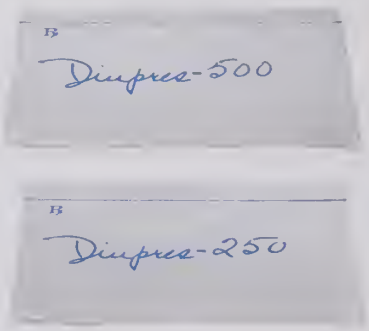
Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.

If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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MEDICINE IN ANCIENT EGYPT—one of a series of oil paintings, "A History of Medicine in Pictures," commissioned by Parke-Davis.

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MATERNAL MORTALITY

(Continued from page 146)

a hospital, but just as the overall mortality has been reduced through patient education for prenatal care we must teach them to utilize the services that are available for their well being. It seems the immediate cause of death in this case was from acute heart failure with pulmonary edema. The patient probably had a chronic anemia and following delivery with the associated blood loss was in mild failure, if not from her reduced blood volume, at least from the reduced oxygen capacity. Had she delivered in the hospital, blood replacement could have been begun much earlier and carried out more slowly. In any event this was felt a direct obstetrical death that could have been prevented.

The 30th Annual Meeting of the Aero Medical Association will be at the Statler Hotel, Los Angeles, California, on April 27-29 according to Charles I. Barron, M.D., Lockheed Aircraft Corporation, general chairman.

NEWS ITEMS

Harold Moberly, Jr., M.D., a native of Richmond, Ky., has opened an office in Winchester for the general practice of medicine. Doctor Moberly graduated from the University of Louisville Medical School in 1955. He interned at St. Elizabeth's Hospital, Dayton, Ohio from 1955-56 and then served as a Captain in the USAF from 1956-58.

Dwight M. Kuhns, M.D., Harlan, received the Carlos J. Finlay Gold Medal and certificate from the Grand Council of the National Order of Merit in Cuba. The award was given for contributions to the control of meningococcal meningitis and bacillary dysentary. Doctor Kuhns is a retired Colonel in the U. S. Army Medical Corps.

Malcolm H. King, M.D., has become associated with **Willam H. Cox, M.D.,** in the general practice of medicine in Paris. Doctor King, a native of Ashland, graduated from the University of Louisville Medical School in 1957 and interned at Louisville General Hospital in 1958.

Madison Cawein, M.D., a graduate of Tulane University School of Medicine in 1954, has opened an office in Lexington for the practice of internal medicine. Doctor Cawein took his internship training at the University of Virginia Hospital and his residency training at the Mayo Clinic. He completed two years of military service in the U. S. Army Medical Corps.

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CASE DISCUSSION

(Continued from page 190)

From the community standpoint all forms of dysentery should be reported and the patient's family surveyed. Fortunately the carrier state with the Shigella organism is much less serious and prolonged as compared with Salmonellosis. However, all cases should be uncovered and treated promptly to prevent further community spread. Carriers and active cases will be subject to varying local Health Board restrictions. In general terms the excreta of the patient should be carefully handled until the cultures are repeatedly negative at least one week after therapy was discontinued.

Man if the only recognized host for the pathogenic Shigella and is therefore the key to control of the disease.

PERTINENT PARAGRAPHS

The 10th annual symposium on Recent Advances in the Study of Venereal Diseases will be held April 27-28, at Johns Hopkins University, Baltimore, Md. The sessions will be open to all physicians and workers in allied fields who are interested in the venereal diseases. The symposium will precede a Venereal Disease Seminar for public health personnel of 14 states, beginning April 29.

The Southwestern Society of Nuclear Medicine will hold its fourth annual meeting at the Roosevelt Hotel in New Orleans, Louisiana, on March 14-15, according to Samuel B. Nadler, M.D., New Orleans, chairman of the program committee.

Health insurance in the U. S. expanded on many levels in 1958 to continue the steady growth it has maintained for the last 20 years, the Health Insurance Institute reported recently. A new record was reached when an estimated $4.8 billion in health care benefits were paid by all insuring organizations during 1958 to help the public meet the cost of accident and sickness. This surpassed the 1957 benefit payment figure of $4.2 billion by more than 14 per cent. It was estimated that 121 million people—or 70 per cent of the nation's population—had health insurance at the end of 1958.

Stanley P. Zarlock, Ph.D., staff psychologist at the VA Hospital in Lexington, Ky., believes a disabled person should make a catalog of the abilities he possesses, select a field of work in accordance with those abilities, and try to forget his disabilities. Doctor Zarlock has been blind since he was 19. "Lack of vision, although inconvenient, is not an obstacle to me in my work," he said. Born and reared in Buffalo, N. Y., he received his Ph. D. degree from the University of Buffalo in 1958 and psychology training at the VA Hospital in Buffalo.



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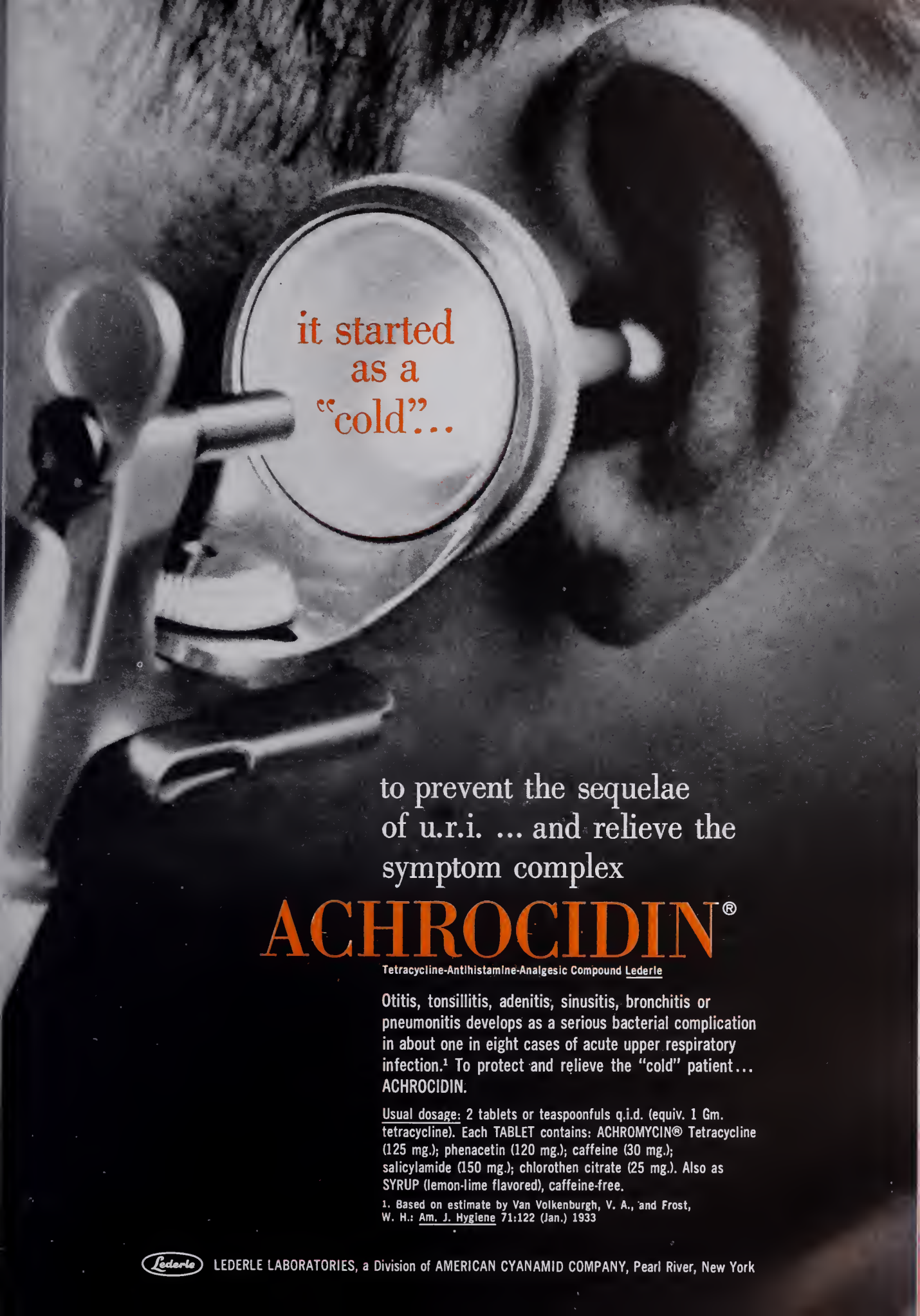
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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PERTINENT PARAGRAPHS

The American Medical Association has announced another series of three regional medicolegal conferences in March and April as part of a continuing effort to create a better working relationship between doctors and lawyers. Dates and locations of the meetings are: at the District of Columbia Medical Society headquarters, Washington, March 20-21; at the Hotel Cleveland, Cleveland, April 4-5; and at the Hotel Utah, Salt Lake City, April 18-19.

Herbert T. Wagner, M.D., Bronxville, N. Y., became new Executive Director of the Medical Society of the State of New York on December 1. W. P. Anderson, M.D., secretary of the Society for many years, who formerly had the dual position of secretary-general manager, will continue as the Society's elected secretary. The New York Society is the largest state medical society in the U. S. and the third largest organized medical group in the world.

The Prudential Auditorium in Jacksonville, Fla., will be the site of the sixth annual seminar on Cardiovascular Diseases on February 19-21. It will be sponsored by the Northeast Florida Heart Association in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida. The course, which has been accepted for credit by the American Academy of General Practice, will include recent developments in the diagnosis and treatment of cardiovascular diseases.

The average person today sees his doctor about five times a year, Health Information Foundation reports. In the aggregate, Americans use between 800 and 850 million physician visits a year.

The typical American nowadays sees a physician almost twice as often as did his counterpart 30 years ago, according to Health Information Foundation—almost 5 visits per person a year today compared with only 2.6 in the 1928-31 period.

Persons in low-income groups now see a physician almost as often as those in high-income groups, says Health Information Foundation. Thirty years ago, by contrast, high-income families averaged about half again as many visits to doctors as did those with the lowest incomes.

Women see physicians more often than men do, especially at the ages of 15 through 44. During childhood, however, boys receive more medical care than girls.

The Mary Putnam Jacobi Fellowship to a graduate woman physician either American or foreign is being offered by the Women's Medical Association of New York. The Fellowship will start October 1, 1959, and will amount to $2,000—$1,000 being available on the October, 1959, date. The remaining $1,000 will be awarded after the completion of four months of study subject to the committee's approval. Applications may be obtained from Ada Chree Reid, M.D., Secretary, 118 Riverside Drive, New York 24, N. Y.

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In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

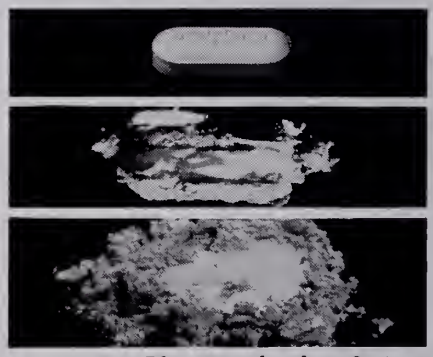
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Acetylsalicylic acid (5 gr.)	300 mg.
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Exactly how does new Halodrin* restore the "premenopausal prime" in postmenopausal women?

Webster defines "prime" as the period of greatest health, strength, and beauty. In a woman, these are the childbearing years between puberty and menopause—the years when her hormone production is highest.

The inevitable reduction in this hormone production as she enters the menopause often results in physical discomfort in the form of hot flushes, nervousness, insomnia, or a multiplicity of other symptoms with which you are familiar. Superimposed on this physical picture is the psychic trauma brought on by this unavoidable evidence of aging. The thing that brings her to a physician is simply that she "feels bad."

You can't make her 35 again—but the odds are good that you can make her feel like it! The secret is a combination of reassurance and hormones. The exact form and amount of the former defy objective analysis, but the latter can now be provided with scientific precision. Reduced to essentials, here is the explanation of exactly how hormones—in the form of Upjohn's new Halodrin—restore the "premenopausal prime."

The normal premenopausal woman excretes estrogens in the urine in the form of estradiol, estrone, and estriol, in an approximate 28-day average ratio of 39:15:46. Starting with this urinary excretion of estrogens, it is possible to calculate backwards and estimate the amount of estradiol that must have been secreted endogenously in order to produce these urinary levels. This is possible because the proportion of estrogens which appears in the urine following parenteral administration has been established in castrated women.

On this basis, the average endogenous output of estrogens is about 160 micrograms per day during a menstrual cycle, and 80 micrograms per day in postmenopausal women (see chart opposite). Therefore, the restoration of the "premenopausal prime" in the postmenopausal woman requires the replacement of approximately the equivalent of the 80 micrograms of estradiol per day that she no longer secretes endogenously.

Oral ethinyl estradiol is about 2 to 2½ times as potent as parenteral estradiol. Therefore, the replacement of 80 micrograms of endogenous estradiol production per day is accomplished by the oral administration of 32 to 40 micrograms of ethinyl estradiol per day.

Each Halodrin tablet contains 20 micrograms of ethinyl estradiol, which means that the recommended dosage of 2 tablets per day provides 40 micrograms of ethinyl estradiol. This offsets the loss of 80 micrograms of endogenous estradiol production in the menopausal woman; i.e., restores the "premenopausal prime."

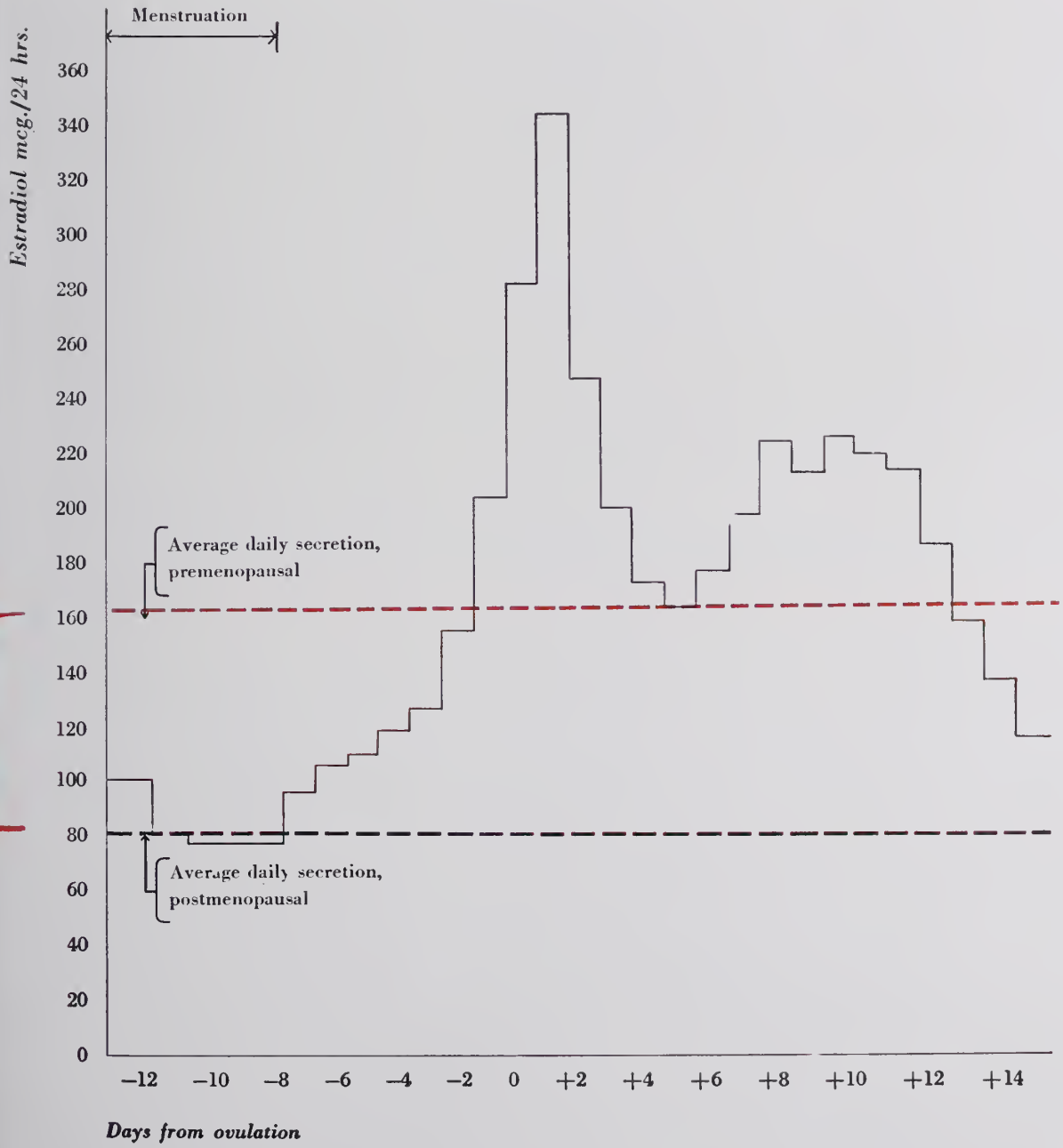
Each Halodrin tablet also contains 1 mg. of Upjohn-developed Halotestin* (fluoxymesterone)—the most potent oral androgen known. The primary purpose is to "buffer" the ethinyl estradiol just enough to prevent breakthrough bleeding, which is obviously undesirable in the menopause. It also exerts other beneficial hormonal effects, one of which, in common with ethinyl estradiol, is a powerful anabolic action so desirable in patients of advanced years.

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Endogenous estrogen secretion (mcg./24 hours) (calculated from average 24-hour urinary excretion of estradiol, estrone, and estriol)



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with SPONTIN®
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In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Sy posium in Washington, D. C., a panel of leading antibiotic experts placed SPONT at the top of all other commercially-availa antibiotics for treating serious staphylococ infections. Also, six papers—all dealing with effectiveness of ristocetin (SPONTIN®) in treat staphylococcal infections—were presented at Symposium.

One of the most encouraging aspects of year's literature on SPONTIN is the increas testimony to its safety. As the months h passed and cases have accumulated by the h dreds, it has become apparent that careful att tion to dosage recommendations has practica eliminated toxicity and side effects as seri obstacles to therapy. Also, recent improveme have been made in the manufacture of SPONT the drug is now made from pure crystals.

A recent report[4] in the Journal of the Am can Medical Association concluded, "It is opinion that, if proper precautions are observ ristocetin is a [well tolerated] and potent ag to employ in the treatment of staphylococ infections." And in another study, after succ fully treating 28 patients with a variety staphylococcal infections, the authors report "No serious complications were noted."

Few more dramatic records have been writ in such a short space of time. SPONTIN has pro itself to be a good answer, perhaps the b answer at present, to the resistant staphylococ problem—and of real value in other seri coccal infections. It may well be your ans when you're confronted with a serious infection.

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STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

pontin In Treating Severe Respiratory Infections "In 13 of 20 patients the results were excellent, ith clinical response being evident within one to our days after institution of therapy. In three addi- onal patients, there was some degree of improve- ent in pneumonic processes superimposed on berculosis in two cases and on pulmonary neo- lasm in one. In all other cases, serious antecedent athology undoubtedly influenced the negative or quivocal response to ristocetin therapy.[6]"

pontin In Treating Staphylococcal Infections—After uccessfully treating 28 patients, the authors wrote, Ristocetin or Spontin has proved to be bactericidal nd bacteriostatic, particularly for the *Staphylo- occus aureus,* which is often resistant to many ther antibiotics.[5]"

pontin In Treating Seven Difficult Cases — "Risto- etin has produced excellent results in eradicating, nitigating or preventing infection in seven selected ifficult cases. Six of the seven cases involved *taphylococcus aureus* which did not respond to hemotherapy with other antibiotics.[7]"

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Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
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6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
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9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.

in corticosteroid therapy of allergic diseases asthma-hay fever allergic rhinitis allergic dermatitis drug reactions



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Excellent and good-to-excellent results are reported† with DECADRON in nearly all of 362 patients with various allergic disorders, including a number of cases who had failed to respond to other corticosteroids. **No major reactions** were observed in these extensive clinical studies even after four months of continuous therapy—DECADRON produced no peptic ulcer, no diabetes, no significant hypertension, no sodium retention, no potassium depletion, no edema, no undesirable psychic reactions, and no unusual or new side effects. Less than five per cent of patients experienced minor reactions, none of which prevented continuing administration of DECADRON.

Moreover, several investigators report that side effects induced by previous corticosteroid therapy such as gastric intolerance, peripheral edema, headache, vertigo, muscle weakness, ecchymoses, flushing, sweating, moon facies, hypertension, hirsutism, and acne **often disappeared during therapy with DECADRON.** †Analysis of clinical reports.

Dosage: One 0.75 mg. tablet of DECADRON will replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Detailed information on dosage and precautions is available to physicians on request.

Supplied: As 0.75 and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100.

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MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

LETTERS
TO THE MEDICAL DIRECTOR

Dear Doctor:

Rauvera* was used on five patients with essensential hypertension varying from moderate to severe. The highest blood pressure was 220/130 and the lowest 180/105.

All patients have shown a consistent response to the drug and the continuation therapy has effected a good control so far . . . approximately two to three months. In four patients systolic blood pressure was reduced from 20 to 50 mm. Hg and the diastolic from 10 to 15 mm. One patient, who had a pressure of 220/130 has had a phenomenal response, and I brought the systolic down to 165 and the diastolic to 95.

M. D., Wisconsin

Dear Doctor:

Rauvera has produced satisfactory reductions of blood pressure in every hypertensive case in which I have used it.

M. D., Colorado

Dear Doctor:

Rauvera tabs are my choice for hypertension over 170 . . . they give me the best results.

M. D., Texas

Comment: *It is interesting to note that no adverse side effects were reported in connection with Rauvera's effective antihypertensive action.*

*Rauvera contains 1 mg. alseroxylon (purified Rauwolfia serpentina alkaloid), 3 mg. alkavervir (Veratrum viride fraction) in each scored tablet.

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We have openings in our NEW DOCTORS BUILDING IN SOMERSET, located directly across the street from the Somerset City Hospital for doctors desiring good practice. One Obstetrician-Gynecoligist, one Pediatrician, one E.E.N.T., and one General Practitioner.

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in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

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Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

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More effective clinically

in LOW BACK PAIN

TORTICOLLIS

BURSITIS and

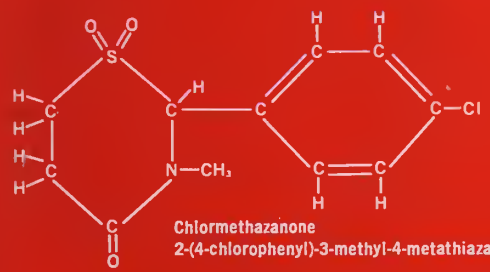
ANXIETY STATES

Trancopal®

the first true tranquilaxant

MUSCLE RELAXANT

and TRANQUILIZER



Chlormethazanone

2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other therapeutic agent in current use. Better tolerated and safer than older drugs.

for clinical results in 4092 patients *see inside*

Trancopal

the first true

*TRANQUILAXANT**

MUSCLE RELAXANT and TRANQUILIZER

clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

Clinical Comments

"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

Baker, University of Minnesota Medical School

"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm,* but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

Lichtman, New York Polyclinic Medical School and Hospital

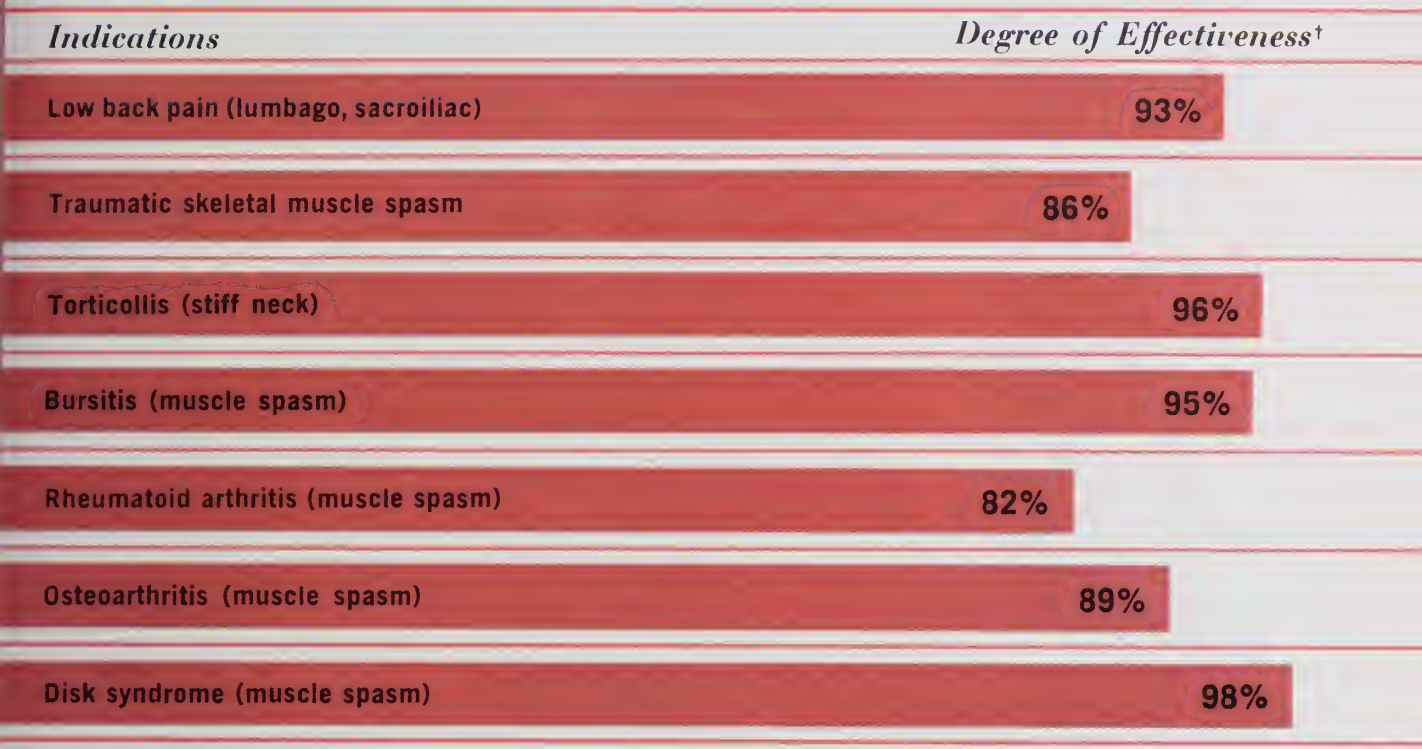
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

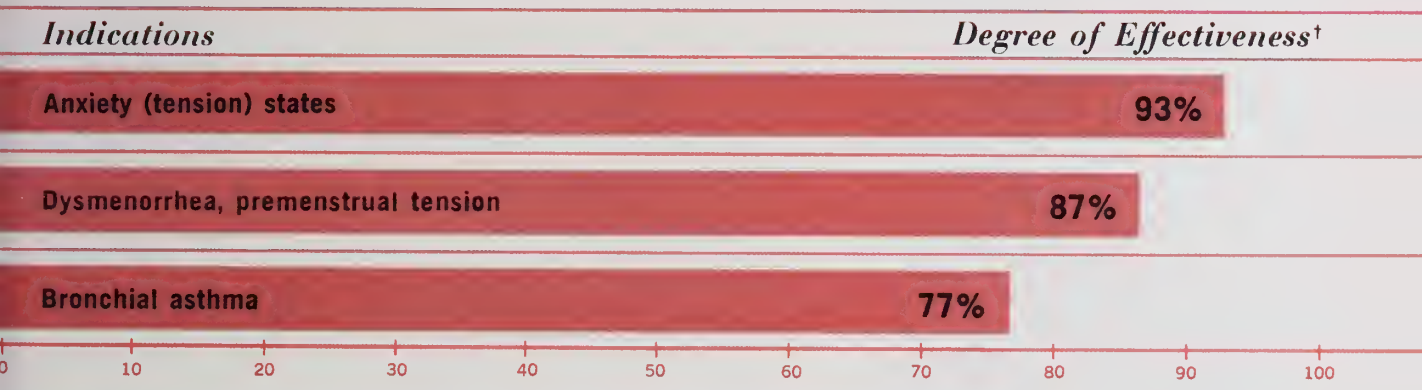
"In 120 patients with *anxiety or tension states,* 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

Lichtman

91% Effective in Musculoskeletal Disorders



89% Effective in Psychogenic Disorders



†*Excellent, good and fair*

The results of clinical studies of over 4092 patients by 105 physicians demonstrate that Trancopal often is effective when other drugs have failed. From these studies it is clear that Trancopal probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other pharmaceutical agent in current use.

Dosage:
Usual adult dose, 1 Caplet (100 mg.) three or four times daily. Children (from 5 to 12 years), ½ Caplet (50 mg.) three or four times daily.

Supplied:
Trancopal Caplets® (peach colored, scored) 100 mg., bottles of 100 and 1000.



Winthrop

Trancopal

the first true tranquilaxant

MUSCLE RELAXANT and TRANQUILIZER

ADVANTAGES OF TRANCOPAL

- Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.
- No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- Low toxicity. "As safe as aspirin."
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.
- No perceptible soporific effect, even in high dosage.

INDICATIONS

Musculoskeletal

Low back pain (lumbago)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
Joint disorders (ankle sprain, tennis elbow, etc.)
Myositis
Postoperative myalgias

Psychogenic

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

Neurologic

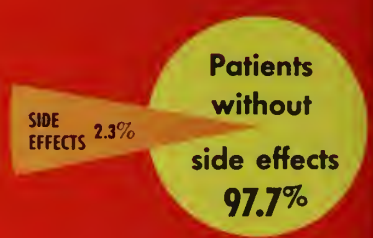
Muscle spasm (in paralysis agitans, multiple sclerosis, hemiplegia, cerebral palsy)

SAFETY

"As Safe As Aspirin"



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4262 PATIENTS.

SUPPLIED

Trancopal Caplets (peach colored, scored) 100 mg., bottles of 100 and 1000.

REFERENCES

1. Baker, A. B.: Drugs to relieve increased tonus, spasticity and rigidity of muscles, Modern Med. 26: 140, April 15, 1958 • 2. Lichtman, A. L.: New developments in muscle relaxant therapy, Kentucky Acad. Gen. Pract. J. 4: 28, Oct., 1958 • 3. Mullin, W. G., and Epifano, Leonard: To be published • 4. Lichtman, A. L.: To be published. • 5. Cooperative Study, Department of Medical Research, Winthrop Laboratories.

Winthrop Laboratories • New York 18, N. Y.

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Lowers blood pressure — maintains mental alertness

calms the patient under stress

Rautensin provides a smooth, gradual and sustained reduction of blood pressure without sudden rebounds or abrupt declines.[1] Rautensin's tranquilizing properties calm the tense and anxious hypertensive without impairing alertness, without producing excessive lethargy or drowsiness.

The risk of Rauwolfia-induced depression is markedly reduced since the alseroxylon fraction alone is used.[2] Even on long-term administration side actions "...are either completely absent or so mild as to be inconsequential."[3]

Rautensin®

Each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

1. Wright, W. T., Jr.; Pokorny, C., and Foster, T. L.: Kansas M. Soc. *57*:410, 1956. 2. Gilchrist, A. R.: Brit. M. J. *2*:1011 (Nov. 3), 1956. 3. Terman, L. A.: Illinois M. J. *3*:67, 1957.

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- *Extremely wide range of action is particularly reassuring when culture and sensitivity testing is impractical*

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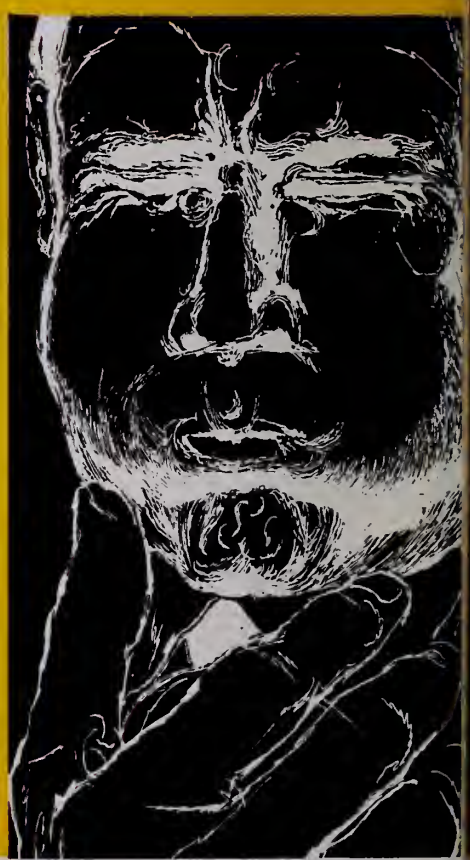
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penicillin V

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THOSE
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IN FILMTAB® / IN ORAL SOLUTION
AND IN COMBINATION WITH SULFAS

illin®-VK

(POTASSIUM PENICILLIN V)

DICATIONS

ainst all penicillin-sensitive organisms. When nbined with Sulfas, COMPOCILLIN-VK is ecially effective in treating mixed infections h as may occur in the respiratory or urinary ct.

SAGE

nge is from 125 mg. (200,000 units) three es daily to 250 mg. (400,000 units) every r hours. Children's dosage is determined by ly weight. When combined with sulfa triad, ge is one Filmtab three times daily to two ntabs every four hours.

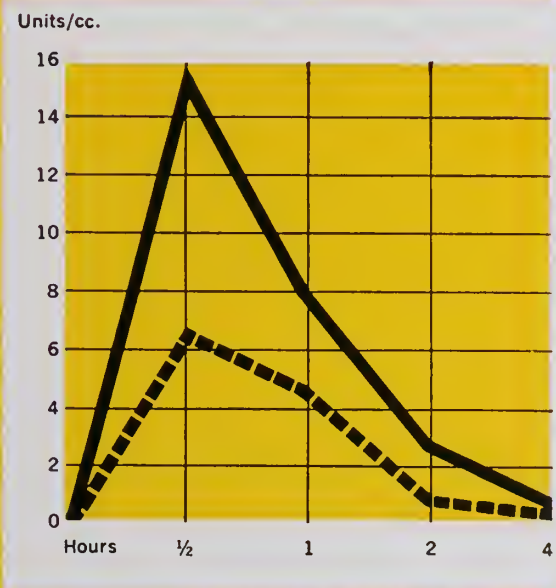
PPLIED

MPOCILLIN-VK Filmtabs: 125 mg. (200,000 ts), bottles of 50 and 100; 250 mg. (400,000 ts), bottles of 25 and 100.

MPOCILLIN-VK Granules for Oral Solution: 40-cc. and 80-cc. bottles. When reconsti- ed, each tasty 5-cc. teaspoonful of cherry- ored solution represents 125 mg. (200,000 ts) of potassium penicillin V.

MPOCILLIN-VK with Sulfas: Each Filmtab tains 125 mg. (200,000 units) of potassium icillin V and 500 mg. of sul- amides. At all pharmacies.

Abbott



The highest levels of Filmtab Compocillin-VK.

The median levels of Filmtab Compocillin-VK.

Note the high upper levels and averages at ½ hour, and at 1 hour.

Doses of 400,000 units were administered before meal-time to 40 subjects involved in this study.

®FILMTAB—FILM-SEALED TABLETS, ABBOTT. PAT. APPLIED FOR.

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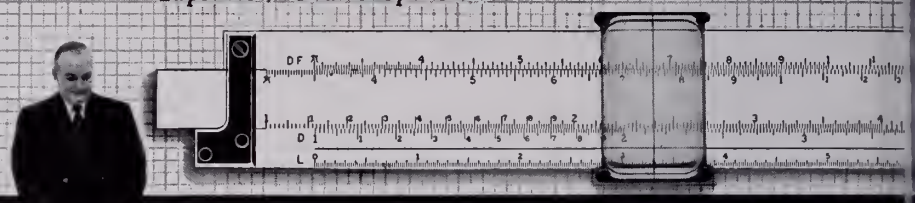
PRONOUNCED TAY-O

Tao

(triacetyloleandomycin)

Capsules / Oral Suspension

* *designed for superior control of common Gram-positive infections*

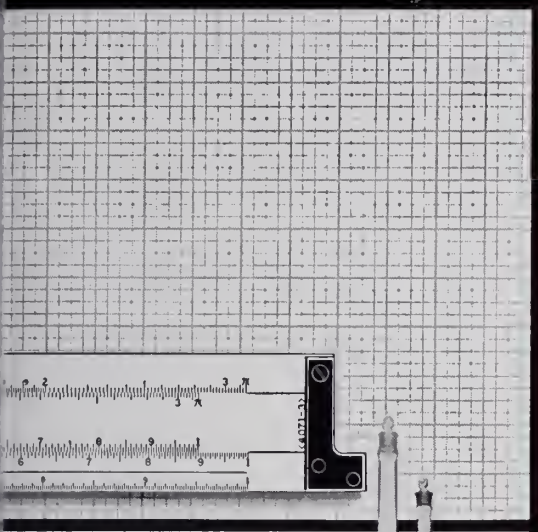




in the patient:

95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	–	6
Otitis media	31	29	2	–
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	–
Abscesses	51	43	8	–
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	–
Pyoderma	19	19	–	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	–
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	–
Urethritis with gonorrhea or cystitis	8	8	–	–
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	**30**	**8**	**4**

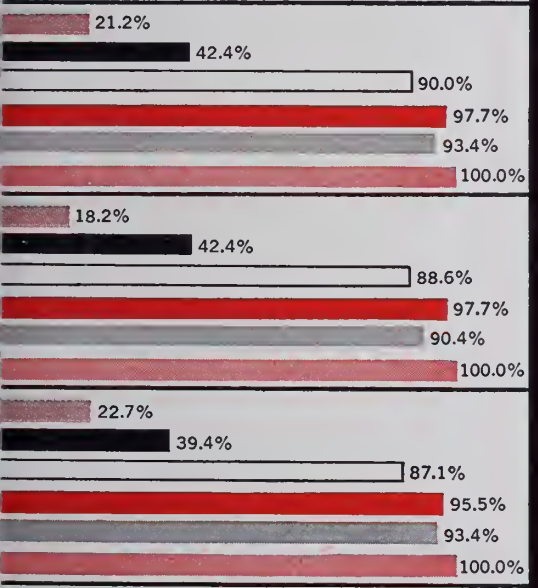


n the aboratory:



ver 90% effective gainst resistant staph

MPARATIVE TESTS BY THREE METHODS
SC, TUBE DILUTION, CYLINDER PLATE)
130 STAPHYLOCOCCI[9]



rcentage of organisms inhibited by the range of
ncentrations listed for each antibiotic.

Other Tao advantages:

Rapidly absorbed – stable in gastric acid,[7] TAO needs no retarding protective coating

Low in toxicity – freedom from side effects in 96% of patients treated; cessation of therapy is rarely required

Highly palatable – "practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults**, the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

Supplied: TAO Capsules – 250 mg. and 125 mg., bottles of 60. TAO for Oral Suspension – 1.5 Gm., 125 mg. per teaspoonful (5 cc.) when reconstituted; unusually palatable cherry flavor; 2 oz. bottle.

References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

TAO dosage forms – for specific clinical situations

TAO Pediatric Drops

For children – flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers – 5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

TAO-AC (TAO analgesic, antihistaminic compound)

To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

TAOMID* (TAO with triple sulfas)

For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action – in clinical emergencies.

Supplied: In 10 cc. vials.

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VARIDASE* BUCCAL TABLETS

Streptokinase-Streptodornase Lederle

Controls Inflammation and Swelling...Relieves Pain... Promotes Healing Through Enchancement of Fibrinolysis at the Site of Trauma or Infection.

References: 1. Innerfield, I.; Shub, H., and Boyd, L. J.: New England J. Med. 258: 1069 (May 24) 1958. 2. Miller, J. M.; Godfrey, G. C.; Ginsberg, M. J., and Papastrat, C. J.: J. A. M. A. 166:478 (Feb. 1) 1958. 3. Davidson, E; Prigot, A., and Maynard, A. de L.: Harlem Hosp. Bull. II: 1 (June) 1958 *Reg. U. S. Pat. Off.



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Now, Parenteral Effectiveness . . . Simple Buccal Route: New VARIDASE Buccal Tablets give your patients the benefits of systemic VARIDASE therapy without the inconvenience of repeated injections. Absorbed through the buccal mucosa in fully effective amounts, VARIDASE Buccal Tablets may be used as practical adjunctive therapy in your practice within these broad classifications:

Inflammation and edema associated with: trauma and infection • cellulitis • abscess • hematoma • thrombophlebitis • sinusitis • uveitis • chronic bronchitis • leg ulcer • chronic bronchiectasis.

Each VARIDASE Buccal Tablet contains 10,000 Units Streptokinase and 2,500 Units Streptodornase.

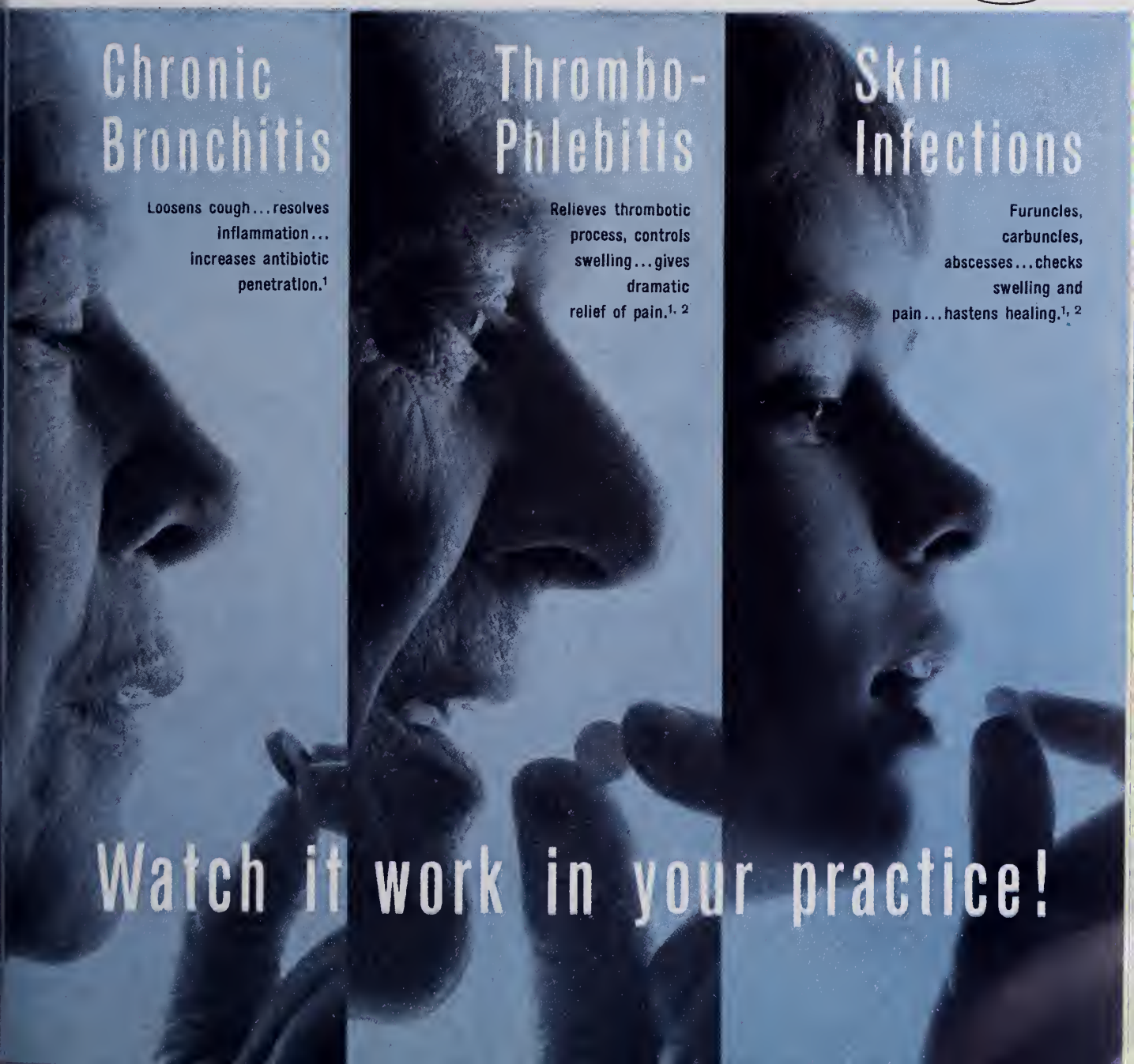
Administration: VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption patient should delay swallowing saliva.

Dosage: One tablet four times daily for a minimum of three days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with an antibiotic such as ACHROMYCIN* V Tetracycline and Citric Acid.

Available in bottles of 24.

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LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York





running noses



and open stuffed noses orally

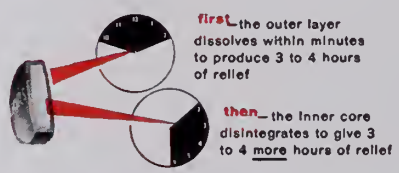
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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in peptic ulcer

Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."

Alglyn®

Dihydroxy aluminum aminoacetate, N.N.R.

In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

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On the contrary, the problem here in Kabul is *not enough* food!

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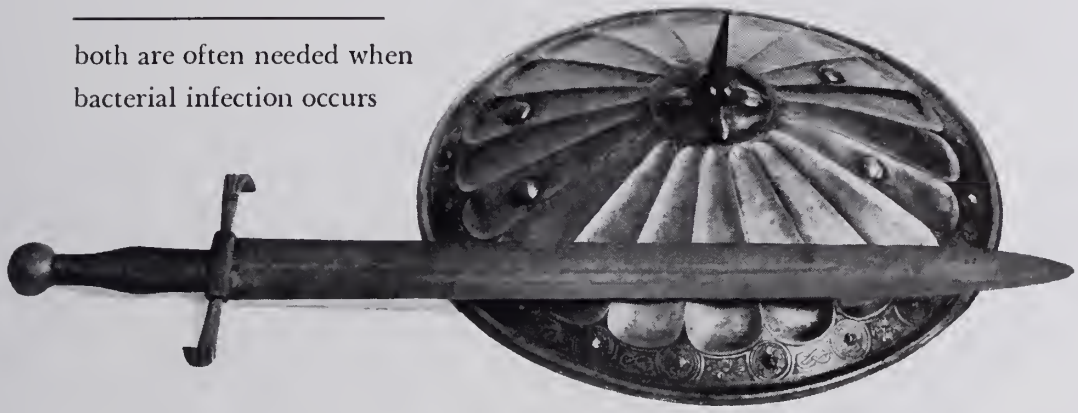
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▮ prompt, aggressive
antibiotic action
▮ a reliable defense against
monilial complications

---

both are often needed when
bacterial infection occurs



for a direct strike at infection

Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and Endamoeba histolytica).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

for protection against monilial complications

Mysteclin-V contains Mycostatin

It provides the antifungal antibiotic, first tested and clinically confirmed by Squibb, with specific action against Candida (Monilia) albicans.

It acts to prevent the monilial overgrowth which frequently occurs whenever tetracycline or any other broad spectrum antibiotic is used.

It protects your patient against antibiotic-induced intestinal moniliasis and its complications, including vaginal and anogenital moniliasis, even potentially fatal systemic moniliasis.

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Allergy in General Practice

Sweat Gland Tumors

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IN THREATENED AND HABITUAL ABORTION:

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message from the President

SOME of you still have faith in the Gallup Polls, despite the fact that they don't always accurately predict the election of the President of the United States. A survey not long ago listed the five top sectors of newspaper reader interest. First on the list was health news of medical science and practice.

In summary, Dr. Gallup says, "Health is certainly one of the great and continuing interests of the public, and health problems and the way medical science is solving them could and should be covered in an endless series of special articles."

Some critics feel nothing should be said about a new therapeutic until it has been fully proved. But when is a drug fully proved? We all remember calling sulfanilamide and the other sulfas the wonder drugs and we thought for awhile we had a cure for almost any disease.

In World War II we not only gave it intravenously and by mouth, but we frosted all wounds with its powders. Today the sulfa drugs have been largely replaced by what we think are better chemotherapeutic remedies. Yet, in the meantime it saved lives and prevented suffering. Just because sulfanilamide had some drawbacks was no reason for not reporting the many good things it would do. Surely the suffering patient is entitled to hope and to every scrap of encouragement he can get.

We have all been disturbed, and rightly so, about many things the press has printed which we felt hurt our profession. Personally, I feel that these areas of misunderstanding are shrinking and that there is a stimulating atmosphere making for better cooperation and I think there is some changed thinking of the press. The newspaper has accepted, and honors, the inalienable rights of privacy of the doctor-patient relationship. It realizes your professional mission of the saving of life and health of the people. As for the legal rights of the patient, we can feel assured that the responsible newspaper has them constantly in mind against the hazard of libel and damage actions.

Likewise, I feel our profession has a growing respect for the right of the public to know. Somewhere in the principles of medical ethics, the doctor is warned that "Refusal to release material may be considered a refusal to perform a public service.

So even if we do feel the press has been unfriendly in the past, let's be kind, cooperative and considerate to them. We need their friendship and they need ours.

Robert W. Roberton



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IN THE BOOKS

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

A COMPENDIUM OF RESEARCH AND THEORY ON STUTTERING: by Charles F. Diehl, Ph. D.; published by Charles C. Thomas, publisher, Springfield, Ill.

GYNECOLOGIC RADIOGRAPHY: by Jean Dalsace, M.D., and J. Garcia-Calderon, M.D.; published by Paul B. Hoeber, Inc., Medical Book Department, Harper and Brothers, New York.

LONG-TERM ILLNESS: edited by Michael G. Wohl, M.D.; published by W. B. Saunders Company, Philadelphia and London.

THE MANAGEMENT OF FRACTURES AND DISLOCATIONS: An Atlas, Volumes I and II; by Anthony F. DePalma, M.D.; published by W. B. Saunders Company; Philadelphia and London.

PHYSICAL DIAGNOSIS: by John A. Prior, M.D., and Jack S. Silberstein, M.D.; published by C. V. Mosby Company, St. Louis, Mo.

PRACTICAL DERMATOLOGY: by George M. Lewis, M.D., published by W. B. Saunders Co., Philadelphia and London.

VASCULAR SURGERY: by Geza de Takats, M.D.; published by W. B. Saunders Company, Philadelphia and London.

THE DOCTOR BUSINESS: by Richard Carter, published by Doubleday and Company, Inc., Garden City, N. Y., 283 pages; price, $4.

The author states that this book is an "Analysis of how the practices of the American Medical Association influence your doctor, your pocketbook, and your health." He then, in an opinionated manner, which is definitely anti-AMA, strives to show that the private practice of medicine is wrong, costly, antiquated and offers a poor substitute for clinic, group or foundation type of practice.

The author writes well, but his logic and conclusions at times are quite faulty. He readily accepts as evidence and the whole truth the utterances of anyone opposed to the private practice of medicine and the AMA. His so-called evidence lacks proof, and some of his statements are part truths and some are unfounded and false.

He vows the AMA is deliberately causing a doctor shortage by limiting the number of medical schools, and, also by not freely admitting all foreign doctors who wish to practice here.

He constantly assails medical economics, and would wholly endorse pre-paid plans. He accepts as the acme of perfection such plans as the Permanente, the Health Insurance Plan of Greater New York. He covers what he calls "The Scandal in the Coal Fields." He believes that such groups, etc., practice much better medicine than is possible by an individual. He, like other torch bearers, would blame all doctors for the acts of a few.

This is a most interesting book and should be read by all physicians; and perhaps it would be well to get a biography of Richard Carter and try to locate the cause of his venom.

E. B. Mersch, M.D.

BREAST CANCER, The Second Biennial Louisiana Cancer Conference, New Orleans, edited by Albert Segaloff, M.D.; published by C. V. Mosby Co., St. Louis, 1958.

This book is rather unique in that it is a compilation of papers, presented at the Second Biennial Louisiana Cancer Conference, held in New Orleans in January of 1958, and was sponsored by the American Cancer Society of Louisiana. At this symposium, outstanding clinicians and research workers in the field of breast cancer were participants and each spoke on the topic or field of interest with which he was most familiar.

This results in a very interesting group of papers on all aspects of breast cancer, from the epidemiological to experimental carcinogenesis to hormonal treatment of advanced breast cancer. Practically all phases of research and also treatment in this field are covered. There is, however, no continuity in the selected topics, and the impression the reader gains is that it is somewhat disjointed in its effect. There are a good deal of data and reports that are of interest only to those who are primarily interested in breast diseases and breast cancer. In other words, this book would not hold much appeal for the general practitioner or the general surgeon who sees only an occasional breast case.

As to controversial issues, this book is very good in that it presents more than one approach to such discussion topics.

In summary, the book is very interesting, particularly to those whose work is, in a large part, that of breast surgery; but actually it will have little appeal or usefulness for the general practitioner.

David W. Kinnaird, M.D.

ORTHOPEDIC DISEASES: by Ernest Aegerter, M.D., and John A. Kirkpatrick, M.D., published by W. B. Saunders Company, Philadelphia and London; May, 1958; 602 pages; 354 illustrations; price, $12.50.

This is an unusual book, from the standpoint of the method of presentation of the material.

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(Continued on page 270)

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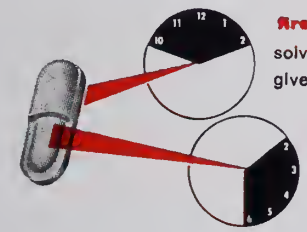
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†Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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1. Landes, R. P. and Peters, M.: Postgrad. Med. 23:648, June 1958.

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PUBLIC HEALTH PAGE

Kentucky Poison Control Program

RUSSELL E. TEAGUE, M.D.
Commissioner of Health, Commonwealth of Kentucky

ONE of the fastest growing items demanding the physician's time is the treatment of cases of accidental poisoning. Recent advances in organic and inorganic chemistry, in manufacturing processes, advertising, marketing and distribution have put a huge variety of synthetic and natural substances of potentially toxic character in almost every household. The Committee on Toxicology of the American Medical Association estimates that over 250,000 different trade-name substances are currently on the market. It is, of course, impossible for any physician to be aware of the toxic chemicals contained in all of these and to know the most effective treatment.

Every day about eight people in the United States die from accidentally or intentionally swallowing some substance capable of causing death. During 1957, fifty-seven Kentuckians died from this cause. Morbidity estimates run as high as 700 non-fatal cases for every fatality. This is a problem that challenges the practicing physician, public health, and many interested groups and organizations.

To meet this challenge in Kentucky, eleven official and non-official organizations have banded together to pool their resources and know-how. This joint effort is known as the Kentucky Poison Control Program. It is guided by an Executive Committee composed of a representative from each of the member organizations. Members include the following:

(1) College of Pharmacy, University of Kentucky
(2) Agricultural Experiment Station, University of Kentucky
(3) Kentucky State Medical Association
(4) Kentucky State Dental Association
(5) Rural Health Conference
(6) Kentucky State Pharmaceutical Association
(7) Kentucky Chapter, American Academy of Pediatrics
(8) Kentucky State Nurses Association
(9) Kentucky Hospital Association
(10) Kentucky Veterinary Medical Association
(11) Kentucky State Department of Health

In addition, the directors of the several Poison Control Centers elect a voting representative.

The four primary objectives of the Kentucky Poison Control Program are as follows:

(1) The inauguration of a program of public education directed toward effecting a greater sense of "poison awareness" among the citizens of Kentucky.

(2) The establishment and maintenance of emergency treatment centers.

(3) The establishment and maintenance of poison information centers.

(4) The continuous accumulation, evaluation, and utilization of poisoning information arising from the activities of the member poison control centers.

The Poison Control Program is implemented through Member Poison Control Centers. These centers may be of two types. Those designated as Class I offer both information and treatment and serve specific regions. The Executive Committee makes all efforts to furnish the maximum volume of material for use by Class I centers including, (a) periodic bulletins from Executive Committee, (b) file card system and addenda prepared by National Clearinghouse for Poison Control Centers, and (c) all file cards prepared and distributed by the Central Information Sub-Committee of the Kentucky Poison Control Program.

These centers are maintained on a 24-hour basis, and are located in the pharmacy or emergency room of the larger hospitals over the state. At this writing, centers are in operation at the following places:

(1) General Hospital, Louisville
(2) Western Baptist Hospital, Paducah
(3) Central Baptist Hospital, Lexington
(4) St. Luke Hospital, Fort Thomas

Others expected to be in operation soon:

(1) Bowling Green-Warren Co. Hospital, Bowling Green
(2) King's Daughters Hospital, Ashland
(3) Harlan Memorial Hospital, Harlan

Class II centers are local (community) centers which can give limited services. At present, none of these are in operation.

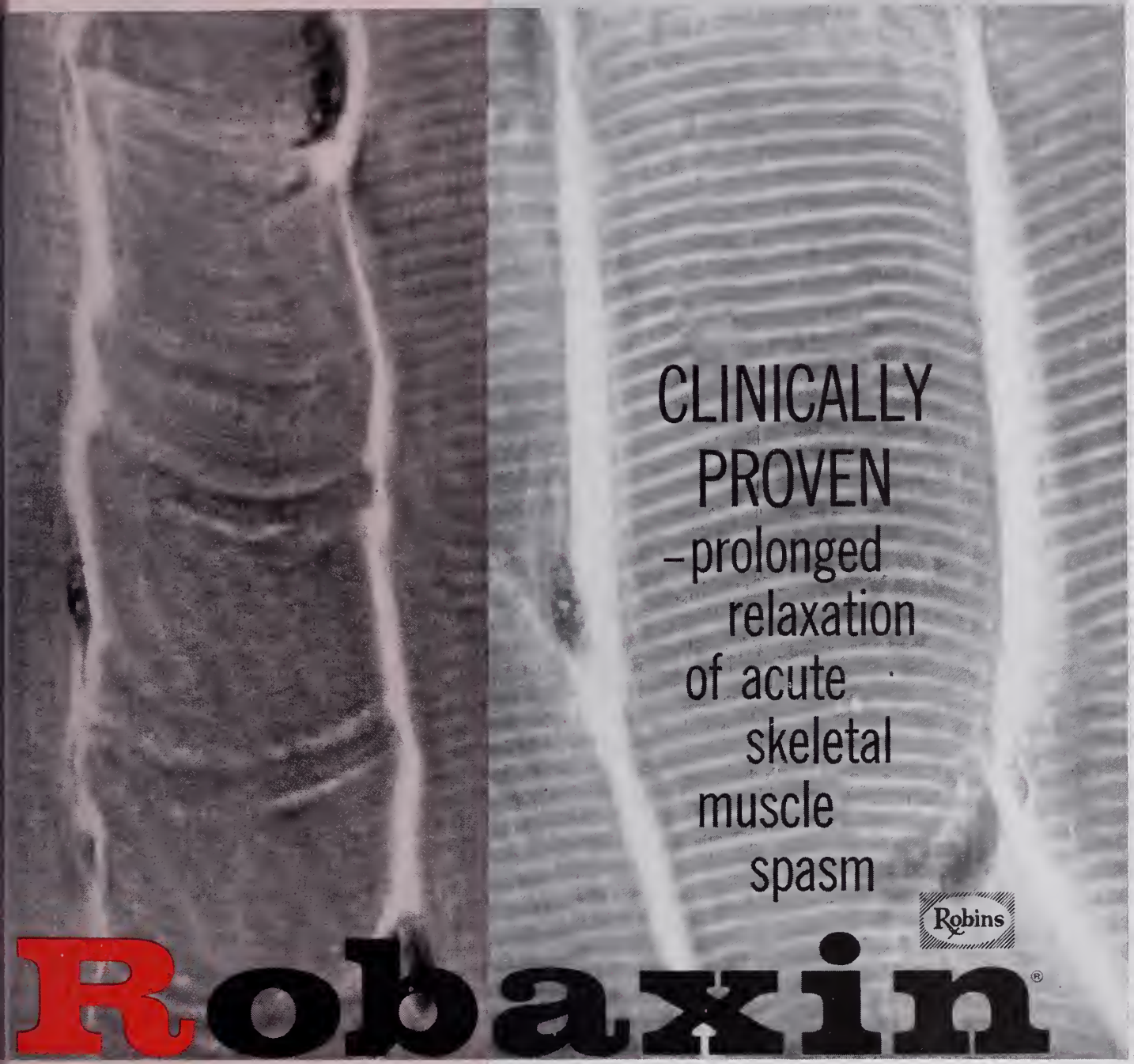
While it is up to the individual centers as to what information will be given lay callers, all centers emphasize that the information function is primarily for practicing physicians and other professional people. To this end, every physician and hospital in the Commonwealth will be notified of the regional center assigned to serve his area.

An integral part of the Poison Control Program is an effort to obtain follow-up investigation on as many reported cases of poisoning as possible. Individual centers report weekly to the Executive Committee who refer the cases to the local health de-

(Continued on page 270)

Fiber of skeletal muscle in spasm

Fiber of skeletal muscle relaxed *(photomicrographs)*



CLINICALLY PROVEN –prolonged relaxation of acute skeletal muscle spasm

Robins

Robaxin®

Methocarbamol Robins U.S. Pat. No. 2770649

TABLETS

Summary of six published clinical studies:

ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
O'Doherty &		"excellent"			
Shields[4]	17	14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Ethical Pharmaceuticals of Merit since 1878

IN THE BOOKS

(Continued from page 264)

Orthopaedic Surgeon, the Radiologist, and the Pathologist.

It is divided into sections of differing numbers of chapters.

1. The First Section has six chapters dealing with the Histology of connective tissue and bone, and bone production. There is a brief chapter on: Radiology of the Skeletal System.
2. The Second Section deals with Congenital Disturbances, Developmental Disturbances, and Functional Disturbances of the Reticuloendothelial System, and Disturbances in Vitamin Metabolism. These chapters are well written and include most of the latest information on these subjects.
3. The Third Section deals with the Repair of Fractures, Circulatory Disturbances, and Metabolic Diseases. Also Parathyroid Disturbances, and a chapter on Infectious Diseases of Bone.
4. The Fourth Section deals with the different type of bone tumors, and contains a wealth of valuable material on this subject.

On page 405 there is a new complete classification of bone tumors, which seems very comprehensive and logical to me.

The book contains many excellent illustrations and photographs of bone and connective tissue pathology.

I feel this book is a very valuable addition to our reference books on these subjects and should be in every Orthopaedists and Radiologists library. It contains much information that will be most helpful to candidates for Specialty Board Examinations in these subjects.

I would recommend it highly.

Richard T. Hudson, M.D.

PUBLIC HEALTH PAGE

(Continued from page 268)

partment. It is emphasized that no investigation will be made without prior approval of the physician concerned.

It is believed we have in the making, potentially, one of the best poison control programs in the nation. Every physician is invited and encouraged to use this service, while lending his cooperation and assistance to this worthwhile movement.

Remember the

Kentucky Public Health Association

Annual Meeting

in

Louisville

March 31-April 1-2

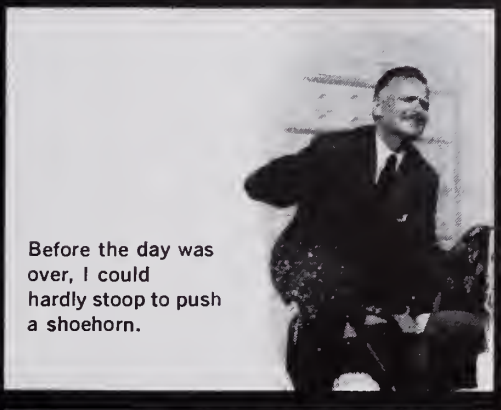


LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY,
Pearl River, New York

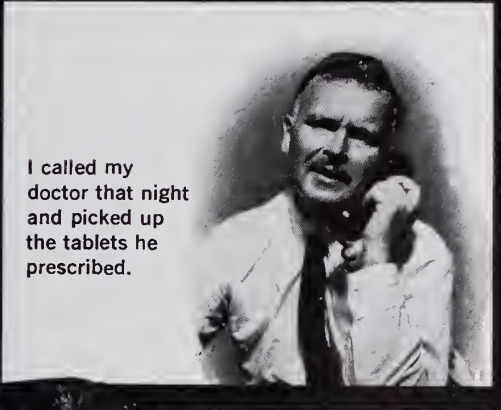
REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



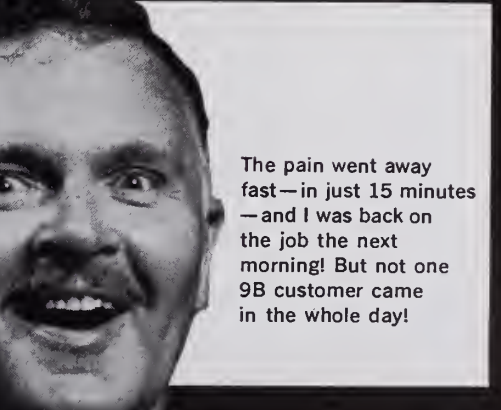
Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.



Before the day was over, I could hardly stoop to push a shoehorn.



I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

Percodan®-Demi & Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

ACTS FASTER — usually within 5-15 minutes. **LASTS LONGER** — usually 6 hours or more. **MORE THOROUGH RELIEF** — permits uninterrupted sleep through the night. **RARELY CONSTIPATES** — excellent for chronic or bedridden patients. **VERSATILE** — new "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

AND THE PAIN WENT AWAY FAST

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,628,185

From the Files of the

Committee for the Study of Maternal Mortality

Case # 48: This patient was a 38-year-old white married gravida 3 para 2 whose LMP was 12/10/57. She was due 9/17/58. Her past history was significant since she had convulsions and temporary blindness with her first pregnancy 18 years ago. She consulted her physician with this pregnancy in her fourth month.

Month of Pregnancy

	1	2	3	4	5	6	7	8 1	8 2	9 3	9 1
Blood pressure				124/80	116/90	120/78	120/78	130/84	172/106	105/80	116/104
Weight				180	182	185	190	201½	205½		119½
Urine								100mg	100mg	30mg	100mg

VDRL non-reactive 3/6/53.

Her present prenatal course was uneventful and uncomplicated until July, the seventh month of pregnancy, when she began to have excessive weight gain, edema, and albumin in the urine. She was placed on "Diuril® 0.5 gm, B I D and a low salt diet" in early August. She made a good initial response but had a gradual increase in edema, albuminuria, hypertension and weight gain.

On August 25 she had a sudden onset of pre-eclamptic symptoms including G-I symptoms. She was hospitalized and treated with "MgSO4, barbiturates, bed rest, and serpersil." The dosage was not given. Her blood pressure dropped (no mention of just how high it was) and her general condition improved; however, her eye grounds showed progressive evidence of papilledema. Consultation was obtained and cesarean section was recommended. No mention was made of vaginal examination to determine the condition of the cervix.

The section, a classical, was done August 30 without complication; the infant, a male, weighed 5 lbs. 7¼ ozs., and apparently got along satisfactorily. For the first 12-15 hours post-operatively the patient showed a normal blood pressure 120/80 but then the pressure gradually began to rise and nausea and vomiting ensued.

Her condition suddenly worsened and she developed respiratory distress. No mention was made of the type treatment at this time only that before anything could be begun the patient suddenly expired.

No post-mortem was obtained.

Clinically the physician felt she demonstrated signs and symptoms of increasing cerebral edema until the final episode which was characterized by respiratory distress and sudden death. The exact cause of death was unknown.

On the death certificate it was given as cerebral edema due to severe pre-eclampsia due to toxemia of pregnancy.

Comment

In retrospect there are several things that may have successfully altered the outcome in this case. Some of these attempts may have been tried, but from the information supplied for study nothing was mentioned of an attempt at vaginal induction. The patient was properly hospitalized when she failed to respond to the ambulatory treatment.

Usually, a multipara, especially within two weeks of term by menses, can be successfully induced with the aid of repeated, observed, pitocin infusions and artificial amniotomy. An attempt was made to control the toxemia in the hospital and five days elapsed before she was sectioned.

Her sudden post-operative death was unexplained. In cases of this type the importance of a post-mortem examination is obvious. Before we can further reduce the number of maternal deaths, we must help the family to realize this is a valuable service available to them in the hospital without cost. The committee hopes to make this true for all maternal deaths throughout the entire state.

in skin disorders

Decadron*



DEXAMETHASONE

treats more patients more effectively
a new order of magnitude in corticosteroid effectiveness
a new order of magnitude in margin of safety

Striking clinical results with DECADRON are reported† in 92 percent of 319 patients with dermatological disorders, including cases previously unresponsive or resistant to corticosteroids. There were no major complications, and even minor side effects occurred in less than eight percent of patients.

Moreover, in many cases reactions induced by previous steroid therapy, such as edema, Cushingoid appearance, headache, vertigo, muscular weakness, depression, hirsutism, and glycosuria, **disappeared during therapy with DECADRON.**

†Analysis of clinical reports.

Dosage: One 0.75 mg. tablet of DECADRON will usually replace one 4 mg. tablet of methylprednisolone or triamcinolone, one 5 mg. tablet of prednisone or prednisolone, one 20 mg. tablet of hydrocortisone, or one 25 mg. tablet of cortisone.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100 and 1000.

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MSD
MERCK SHARP & DOHME
DIVISION OF MERCK & CO., Inc., PHILADELPHIA 1, PA.

re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE NOW SAYING ABOUT ATARAX®

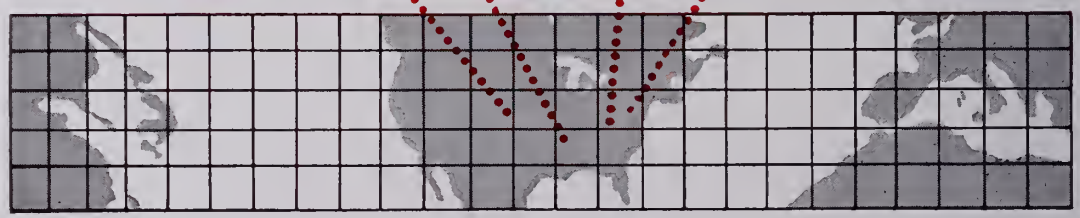
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior . . . ."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety . . . . Its safety makes it an excellent drug for out patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

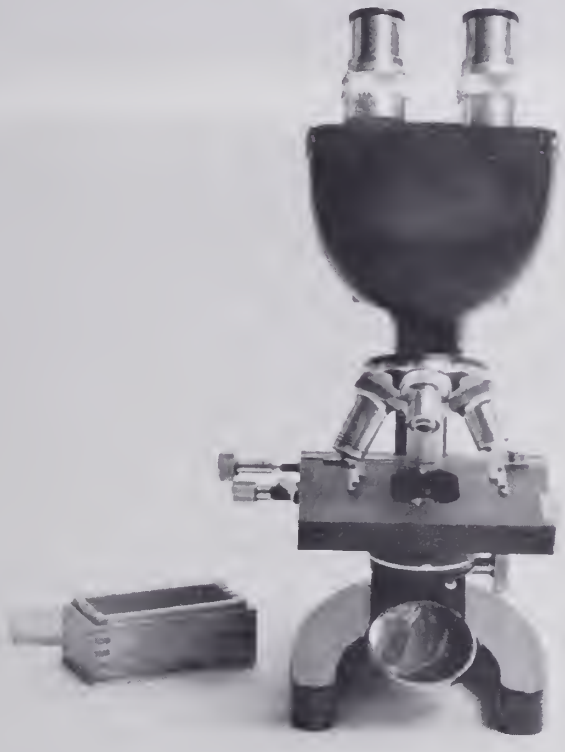
Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Science for the World's Well-Being

for the control of all coccal infections



ABBOTT'S ANTIBIOTIC TRIAD

against staph-, strep- and pneumococci



After Millions of Prescriptions An Unparalleled Safety Record

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Provides fast, high blood and tissue concentrations—Because ERYTHROCIN Stearate is rapidly absorbed, patients get therapeutic blood and tissue levels within 30 minutes—and effective concentrations for at least six hours.

Supported by an unparalleled safety record—During all the years ERYTHROCIN has been prescribed, serious reactions have been practically nonexistent. Unlike penicillin, allergy is no problem. And, in contrast to "broad spectrum" action, the normal intestinal flora is virtually unaltered with ERYTHROCIN therapy. And only recently, a well-known investigator said, "Erythromycin is by far the least toxic of the commonly used antibiotics.[1]"

Offers bactericidal action—Unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal agent. It offers lethal action against common coccic invaders—resulting in prompt clinical responses.

Provides convenient dosage forms—Usual adult dose is 250 mg. four times daily. Children's dosage is reduced in proportion to body weight. ERYTHROCIN comes in Filmtabs® (100 and 250 mg.), bottles of 25 and 100. Also, in oral suspension and for intramuscular and intravenous use. Abbott

1. Herrell, W. E.: Hazards of Antibiotic Therapy, J.A.M.A., 168:1815, December 6, 1958

*Filmtab—Film-sealed tablets. Abbott pat. applied for

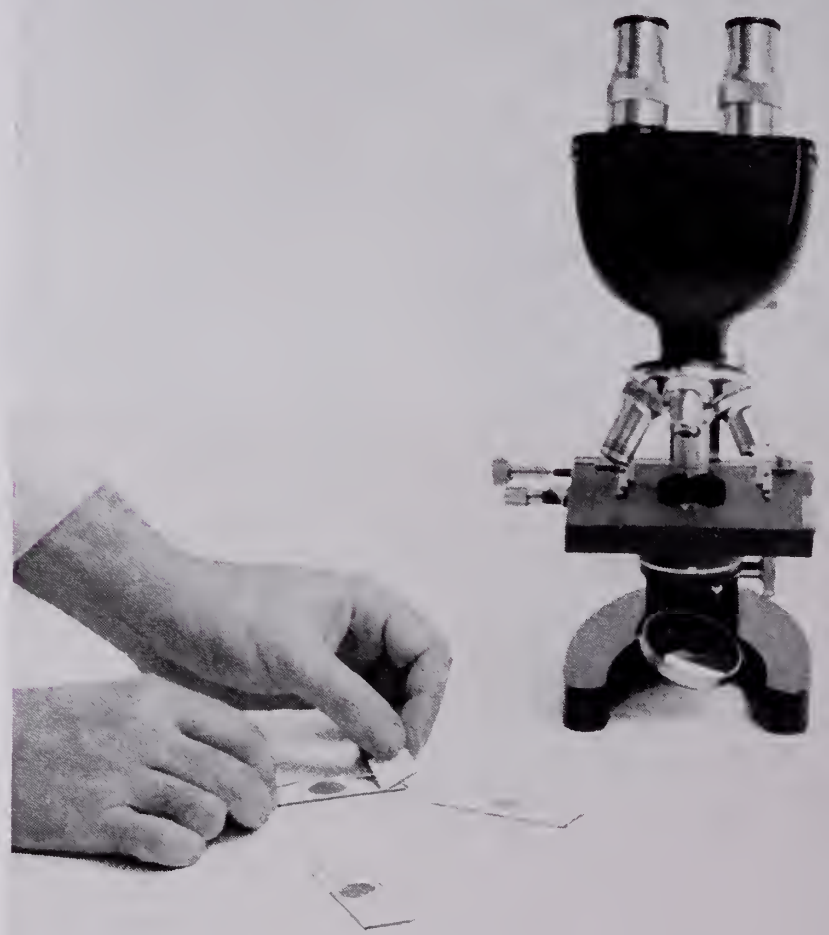
ERYTHROCIN® STEARATE

(Erythromycin Stearate, Abbott)

an uncommon antibiotic

for common infections

for those penicillin-sensitive organisms
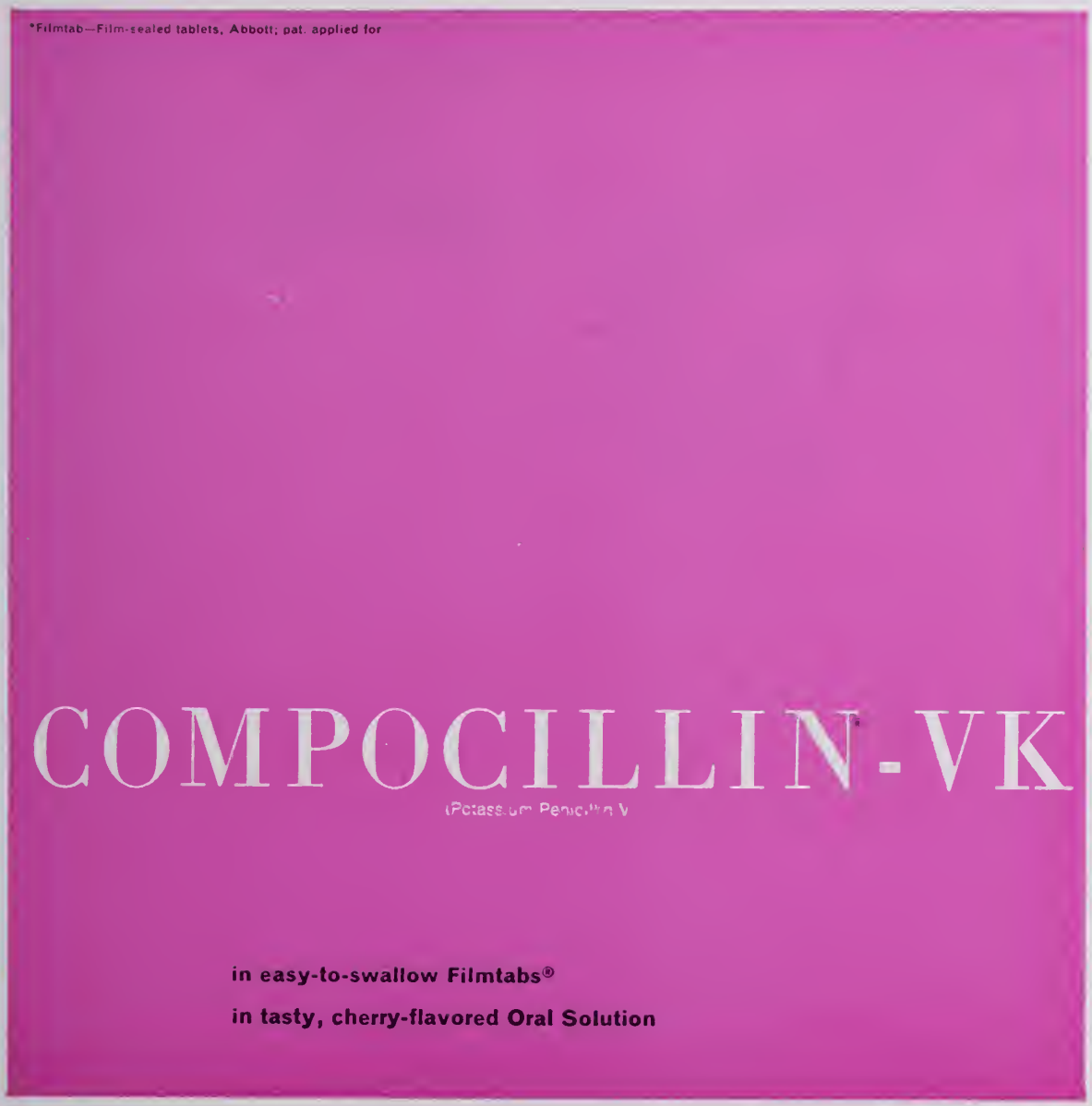


The Higher Blood Levels of Potassium Penicillin V

COMPOCILLIN-VK Indications—Against all organisms sensitive to oral penicillin therapy. For prophylaxis and treatment of complications in viral conditions. As a prophylaxis in rheumatic fever and in rheumatic heart disease.

COMPOCILLIN-VK Dosage—Depending on the severity of the infection, the usual adult dose is 125 mg. to 250 mg. (200,000 to 400,000 units) every four to six hours. For children, dosage may be reduced in proportion to body weight.

COMPOCILLIN-VK Supplied—In Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. For oral solution, COMPOCILLIN-VK comes in 40-cc. and 80-cc. bottles. When reconstituted with water, each appealing (it's a clear red solution) 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

Abbott



against serious and resistant coccal infections



An Important
Lifesaving Antibiotic

The dramatic story of SPONTIN can never really begin to be told.

In little more than a year, this potent antibiotic has compiled an incredible record for saving lives —and often, after all other therapy had failed. Majority of successes involved patients critically ill with staphylococcal infections—conditions that had resisted all other known antibiotic therapy.

Meanwhile, careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

So far, SPONTIN has proved to be a good answer, perhaps the best answer to the resistant staphylococcal problem—and of real value in other serious coccal infections.

Abbott

1. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.

Crystallized

SPONTIN®

(Ristocetin, Abbott)

Prepared from pure crystals

Provides Outstanding Clinical Effectiveness Against Coccal Infections, Including Resistant Staphylococci and Enterococci[1]

Provides Bactericidal Action Against Coccal Infections[1]



WASHINGTON NEWS DIGEST



Washington, D. C.—Contrary to the usual procedure in a first session, the 86th Congress this year already is getting on with its work, particularly in health fields. In past Congresses, not much is accomplished the first session, with most bills held over to the second, which always is an election year.

The session was only weeks old when action was under way. Here are some of the developments, portending enactment before adjournment of a number of bills:

1. After hearings, a subcommittee of the Senate Banking and Currency Committee reported favorably on a housing bill that contained provision for mortgage guarantees for proprietary nursing homes. Subsequently, the measure was passed by the Senate.

At this writing the House is at work on another housing bill that also contains the nursing home loan section. With House passage assumed, the question is whether the bill (containing more money than the White House wants spent) will be vetoed, and if vetoed whether it can be enacted anyway by two-thirds majorities in both houses.

2. Without bothering with hearings, the House Ways and Means Committee overwhelmingly approved the Keogh bill to encourage retirement plans for the self-employed. It acted in line with the committee's established procedure to quickly reapprove bills that passed the House the previous Congress, but not the Senate. The Keogh bill is identical with a measure that easily cleared the House last session but lost out in the Senate.

3. Driven forward by Chairman Carl Vinson of the House Armed Services Committee, legislation to extend the regular and doctor drafts four years rolled through the House. However, indications were the Senate would take its time and give careful consideration to the need for a four-year extension.

4. The Senate Labor and Welfare Committee, under the leadership of Chairman Lister Hill (D., Ala.), demonstrated its interest in legislation for the aged, Senator Hill named a subcommittee to make a full year's study of problems of the aged, taking in housing, employment and recreation, and medical aspects.

Chairman of this subcommittee is Senator Pat McNamara, Detroit Democrat. Other Democrats are Senators John Kennedy of Massachusetts, Joseph Clark of Pennsylvania and Jennings Randolph of West Virginia. Republicans are Senators Everett Dirksen of Illinois and Barry Goldwater of Arizona.

5. At the same time, three members of the standing health subcommittee of the Hill Committee, Senators Jacob K. Javits of New York, Clifford B. Case of New Jersey and John Sherman Cooper, all Republicans, asked Congress to authorize a two-year study of the health problems of the entire population. If approved by Congress, the investigation would look into the quality and quantity of health services, problems of extending health insurance, special problems of the aged and minority groups, and the distribution of health services.

Notes

Fifty-four Senators are supporting legislation that would project the U. S. farther into the international medical picture. It would set up an Institute of International Medical Research as part of NIH, establish an advisory council, and authorize spending of $50 millon a year for research, part of it to go to foreigners in the form of grants.

Medicare has not been able to keep within the $72 million "ceiling" recommended by Congress for the present year. Through the Navy it is asking $6 million more. In addition, Army and Air Force will shift funds to meet the bill, estimated at $93.6 million. The budget asks $89 million for next year, in expectation that restrictions begun in October will bring a saving of between $4 million and $5 million.

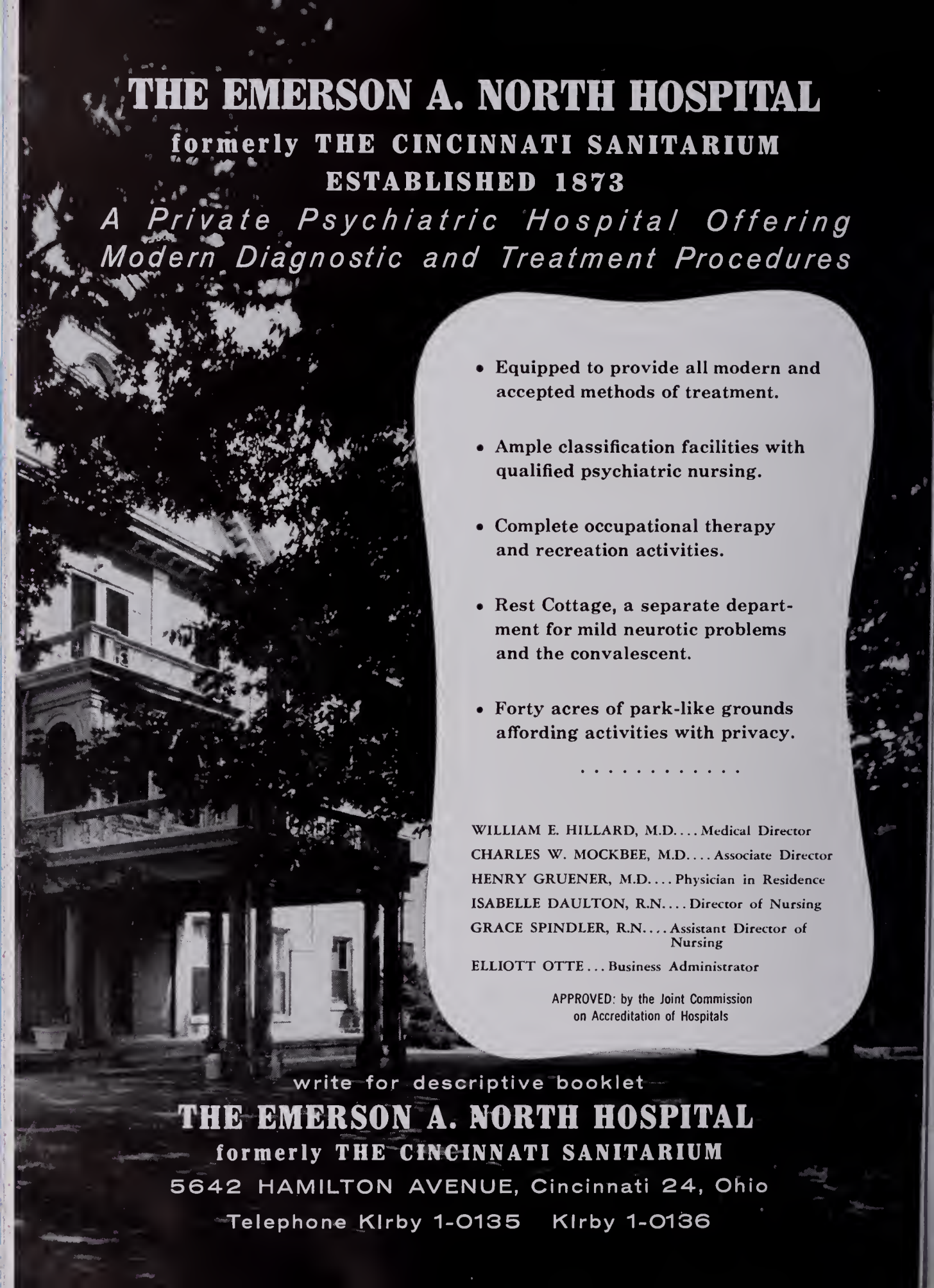
Medicine has won an argument within the new Federal Aviation Agency. As a consequence, FAA's civil air surgeon will assist the administrator in setting standards for fitness, direct physical examination and inspection programs, advise on research needs, and evaluate all of FAA's medical personnel plans.

The President's health budget, now under scrutiny in Congress, is expected to be substantially increased. As an example of the White House efforts for economy, Mr. Eisenhower recommended $101.2 million for Hill-Burton hospital construction grants, in contrast to $186.2 million HB has for the current fiscal year.

"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

Nonbuffered Material Used—Bayer® Aspirin.



THE EMERSON A. NORTH HOSPITAL

formerly THE CINCINNATI SANITARIUM

ESTABLISHED 1873

A Private Psychiatric Hospital Offering Modern Diagnostic and Treatment Procedures

- Equipped to provide all modern and accepted methods of treatment.
- Ample classification facilities with qualified psychiatric nursing.
- Complete occupational therapy and recreation activities.
- Rest Cottage, a separate department for mild neurotic problems and the convalescent.
- Forty acres of park-like grounds affording activities with privacy.

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HENRY GRUENER, M.D. . . . Physician in Residence
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APPROVED: by the Joint Commission on Accreditation of Hospitals

write for descriptive booklet

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all day

NEW

DARICON*

oxyphencyclimine hydrochloride

TABLETS

all night

patient comfort

Natural Prolonged Action–The action of DARICON, a more potent and better tolerated anticholinergic, is consistently prolonged because it has a unique chemical structure and is not dependent on "mechanical" means (e.g., special coating, adsorption on ion-exchange resin).

In addition to peptic ulcer, DARICON is also indicated for other gastrointestinal disorders characterized by hypersecretion, hypermotility and spasm (e.g., functional bowel syndrome, chronic nonspecific ulcerative colitis and biliary tract disease).

Dosage: 10 mg. b.i.d. (morning and evening). **Supply:** Tablets, 10 mg., white, scored. Bottles of 60 and 500.

*Trademark

EVEN REFRACTORY CASES RESPOND

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES

Division, Chas. Pfizer & Co., Inc.

Brooklyn 6, N. Y.

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

CM-8043

enables your patient to escape

peptic ulcer symptoms

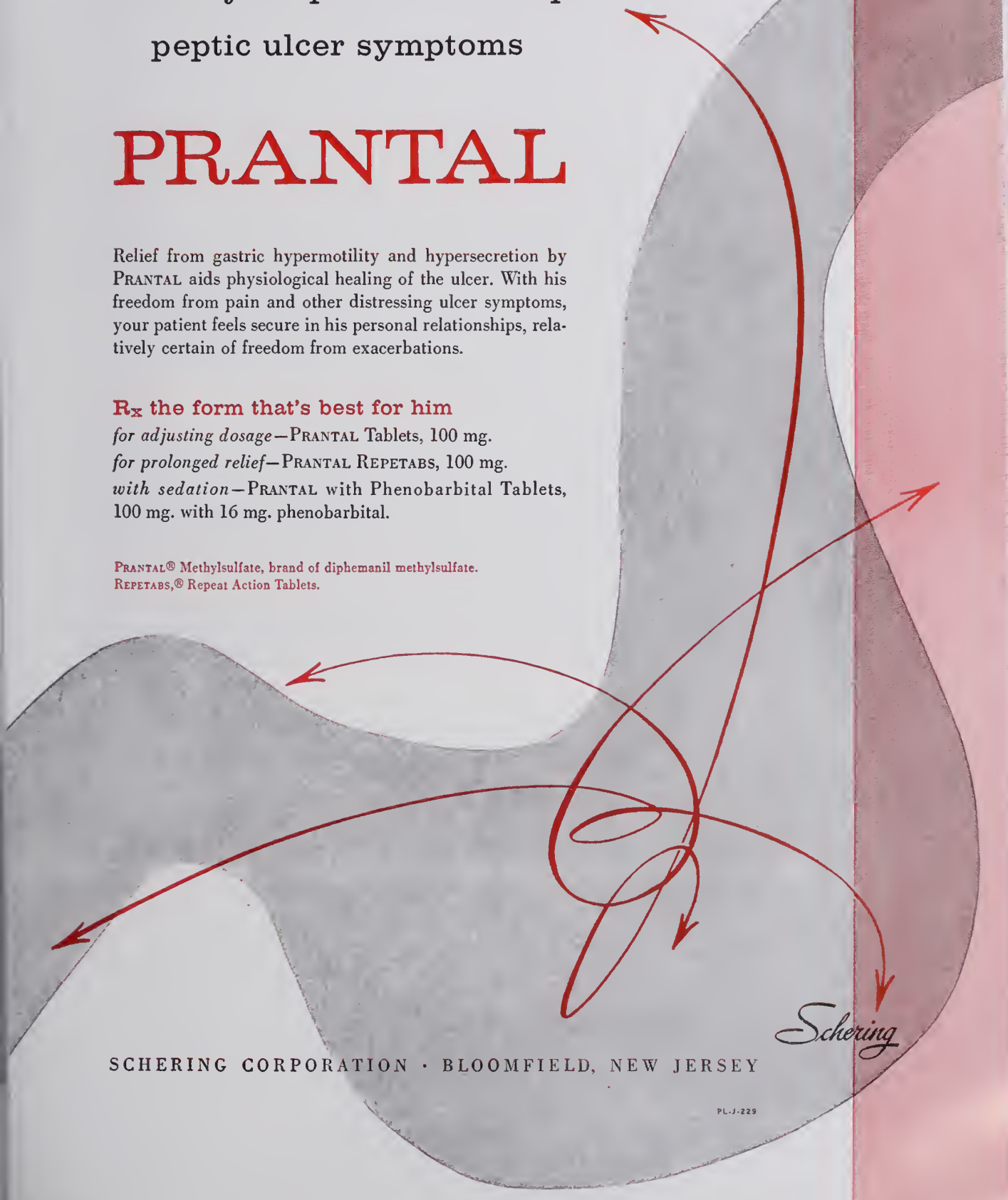
PRANTAL

Relief from gastric hypermotility and hypersecretion by PRANTAL aids physiological healing of the ulcer. With his freedom from pain and other distressing ulcer symptoms, your patient feels secure in his personal relationships, relatively certain of freedom from exacerbations.

R_x the form that's best for him

for adjusting dosage—PRANTAL Tablets, 100 mg.
for prolonged relief—PRANTAL REPETABS, 100 mg.
with sedation—PRANTAL with Phenobarbital Tablets, 100 mg. with 16 mg. phenobarbital.

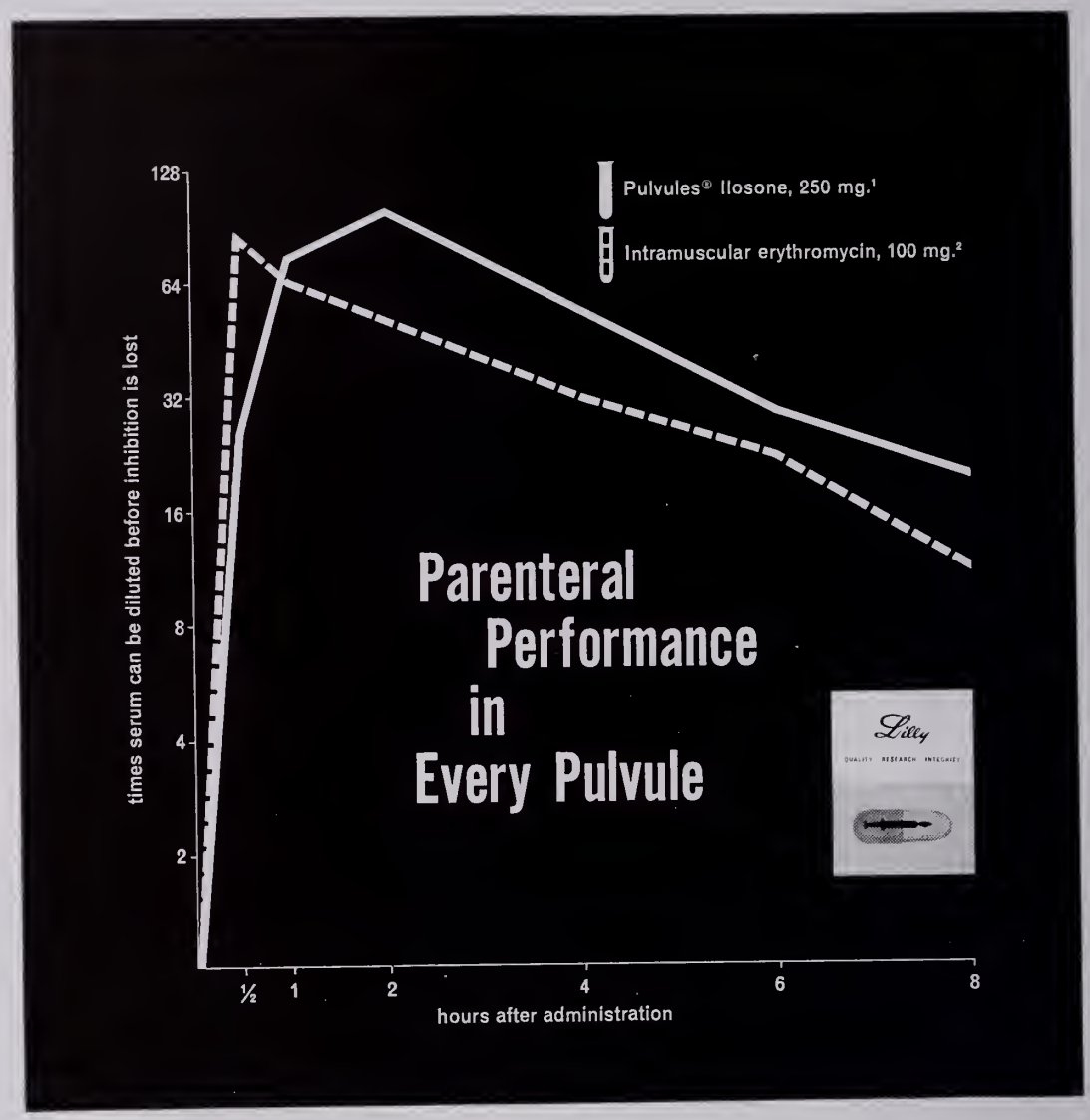
PRANTAL® Methylsulfate, brand of diphemanil methylsulfate.
REPETABS,® Repeat Action Tablets.



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PL-J-229



ILOSONE™ assures a decisive response in common bacterial infections

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1. Antibiotic Med. & Clin. Therapy, 5:609, 1958.
2. Data from Antibiotics Annual, p. 269, 1954-1955.

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Allergy In General Practice *

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Indianapolis, Ind.

ALTHOUGH allergic sensitization generally is thought to be a disease of modern times, this condition was present and recognized long, long ago, even prior to the Christian era. Ancient literature contains many references to certain abnormal conditions which today are recognized as definite allergic reactions. In the first century, B.C., the Roman poet, Lucretius, recognized food allergy, as indicated by his often quoted and very true statement that, "One man's meat is another man's poison," and in 100-200 A.D. the Babylonian Talmud gave explicit directions for treating sensitization to egg by feeding egg white to the patient. Also, in the Middle Ages attacks of asthma and paroxysmal sneezing were known to be caused at times by flowers, trees and other plants and by the eating of certain foods.

The term "allergy" has come to be a common household word. It is used frequently and loosely by many persons to denote disagreeable or unpleasant experiences following contact with individuals or conditions to which they say they are allergic. Such expressions as "allergic to my wife," "allergic to work," etc., are quite popular but, of course, not very scientific.

Causes and Incidence

The word "allergy" is derived from the Greek and in that language means "other energy." The simplest definition of allergic reaction that I know of is the one given by Dr. Jonathan Forman, that "an allergic reaction is an abnormal response by an individual to an ordinarily harmless substance." The harmless substance referred to usually is a protein which is, or was at some time, derived from a living animal or plant. Examples are proteins from foods, from bacteria, from animal danders, as in cat or horse hair, from molds and fungus growths, etc. There is a smaller class of substances which cause reactions on the skin from direct contact with such things as drugs, industrial agents, cosmetics, and many other irritants. Any of these things can cause trouble for an individual if he is sensitized or, as we say, allergic to them.

Various investigators estimate that 10-20% of the entire population have definite allergic disease of some type and that 3-10% have respiratory allergies. An interesting sidelight on these statistics is the observation of Dr. Coca that among the insane less than 0.1% have allergic disease, and in 7000 psychiatric patients MacInviss (reported by Urbach) found that only 0.07% showed allergic symptoms. Also in this group three patients with allergic disease improved or were entirely relieved of allergic symptoms during their mental illness, but upon improvement of the mental conditions, suffered recurrence of their allergies. Those of us who are afflicted with allergic complaints should find some comfort in these observations.

The greatest incidence of allergic disease occurs in the various ramifications of the respiratory tract. Allergic sensitization also frequently is the cause of eczema and other dermatological conditions and of many gastro-intestinal complaints. Many authorities agree that allergic disease may affect every organ and tissue in the body and offer much convincing evidence to support this claim. Allergic disease may begin at birth. The colicky baby with projectile vomiting and eczematous rash probably is sensitized to some food in his diet, such as milk or orange juice. The child may recover from this early manifestation but is very apt to suffer later in life with various other allergic conditions such as hay fever, asthma, dermatitis, gastro-intestinal upsets, headache, allergic sinusitis and a

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host of other complaints and symptoms known to be caused frequently by allergic sensitization.

Diagnosis

Although the practice of allergy rapidly is becoming a highly specialized field, the general practitioner can and should handle many of these cases himself. There are a number of practical and fairly simple diagnostic measures which any physician may readily utilize in his examination of the patient if an allergic condition is suspected. The most important single feature of the examination is a thorough history. This should begin with the patient's family, for in 60-70% of all allergic patients there will be a positive history of allergic complaints in their close relatives. If the patient has this type of hereditary background the presence of allergic disease should be strongly suspected until it can be ruled out. The patient's personal history also is extremely important. Some cases can be solved by a good history alone.

An increase in the eosinophiles in the blood stream or in the nasal secretions is strongly indicative of allergy. In seeking the cause of chronic rhinitis or sinus disease a differential diagnosis between allergy and infection can be made by examination of a stained smear of the nasal discharge. A preponderance of eosinophiles denotes allergy while a preponderance of neutrophiles means infection. Successful treatment depends entirely upon this etiologic differentiation.

Many cases of dermatitis and many gastrointestinal complaints are due to food allergy. Careful quizzing of the patient in regard to his dietary habits often will bring a certain food under suspicion and elimination of this food from the diet may relieve all of the symptoms.

A number of other pathological conditions may produce symptoms which closely simulate allergic disease and which must be considered in the differential diagnosis. Hypothyroidism may produce the stuffy nose, the dull headache, the general lassitude, the pale nasal mucous membrane and other symptoms of allergic disease. It is remarkable how quickly medication with thyroid substance or Cytomel® will relieve symptoms which often are thought to be due to allergy. The pallid grayish appearance of the nasal mucous membranes so typical of allergic disease of the upper respiratory tract may be due to secondary anemia or to malnutrition. Urticarial and eczematous eruptions and other symptoms usually due to allergy may be caused, also, by emotional stress and psychogenic factors. In short, anything which will upset the autonomic nervous system may cause symptoms which simulate true allergic reactions.

Treatment

The best treatment for any type of allergic disease is, of course, complete removal of the offending allergen from contact with the patient. The hay fever victim has no trouble in sections of the country in which the pollen to which he is sensitized does not grow. The person sensitized to animal danders will be relieved of his symptoms as long as he is not in close contact with the cat, dog, horse or other animal producing the specific dander to which he is allergic. Contact dermatitis caused by cosmetics, industrial agents, poison ivy, etc., will cease to irritate the sensitized individual upon removal of contact with these substances. The food sensitive patient will remain symptom free if the offending food is removed from his diet. Most allergy problems are not this simple, of course, but quite often the family doctor can make the diagnosis by means of a careful deductive history and can then give his patient proper and effective advice.

The general practitioner may be called upon at any time to render emergency treatment to an allergic person suffering from anaphylactic shock. This is an extremely serious and dangerous situation and heroic measures must be taken at once. Anaphylactic reaction may be the immediate result of insect stings or of the injection of antigens, antibiotics and other drugs and serums or of other agents to which the patient may be hypersensitized. The victim of anaphylaxis may be seized immediately with any one or all of a severe chain of reactions such as giant hives, edema of the larynx and bronchi, severe asthma, inability to breathe, cyanosis, convulsions, shock and general collapse. The great life-saver in this emergency is epinephrine in the strength of 1-1000. 0.1 c.c. should be injected directly into the wheal or site of the sting or of the prior injection. The needle is then pushed through the wheal into the subcutaneous tissue and 0.4 c.c. more injected there. If the patient's response is not quick and adequate, more epinephrine should be injected. Other drugs of value, to be used intravenously, are amynophyllin, antihistamine

and hydrocortisone.

At times a tracheotomy may be required. In such emergency one does not wait for the arrival of a throat surgeon nor waste valuable minutes searching for a misplaced tracheotomy set but makes the incision and the tracheal opening with the instrument immediately at hand. It has been done with a pocket knife. This recalls the harrowing experience of one of my friends, an otolaryngologist. One morning just before leaving the house he gave his wife her usual hormone and B12 shot. This was a routine procedure and had never before caused any trouble. As the doctor was walking out the front door he heard his wife cry out and fall to the floor. He dashed up the stairs and found her on the floor of the bathroom, blue in the face and evidently about to choke to death. With no time to do down to his car for his instrument bag, he seized his old fashioned straight blade razor and was able to make the life-saving opening into his wife's trachea. Fortunately he was able to revive her and everything turned out well although the doctor himself, who suffered from diabetes and hypertension, also was confined to the hospital for two or three days following this terrifying experience. He told me later of the thoughts which flashed through his mind as he knelt on the floor, about to plunge the razor into his wife's throat. He said, "all I could think of was that she was going to die if I didn't do it and that if she died in spite of it, the police would swear that I had murdered her."

Drug Allergy

All doctors prescribe drugs freely and it might be well to consider the subject of drug allergy for a few minutes. Although it has been known for a long time that some patients developed toxic and untoward reactions from various drugs, it has been only in fairly recent years that many of these reactions have been recognized as true allergic manifestations. Not only is the recognition of drug allergy becoming more common but sensitization to drugs seems actually to be on the increase, especially since the advent and free use of so many new drugs such as the sulfonamides and antibiotics. Attention has been called to severe allergic reactions to thiouracil, hormones, anti-epileptic drugs, vitamins and even to antihistamine. Some of the older drugs now known to cause allergic reaction, such as amidopyrine and arsphenamine have largely been discarded, but many offending drugs of this type are still in common use. Among these may be mentioned especially such well-known and widely used drugs as arsenic, atabrine, barbiturates, bromides, iodides, benzocaine, Nupercaine,® Butyn,® insulin, liver extract, quinine, mercury, phenolphthalein, codeine, etc. Severe anaphylactic shock and even death have been reported from relatively small doses of the universal household remedy, aspirin.

Sensitization to drugs may cause all of the common allergic symptoms; rhinitis, asthma, urticaria, contact dermatitis and anaphylactic shock. Drug allergy also may produce reactions which only rarely occur in food or inhalant allergy, such as fever, skin rash, arthralgia, hepatitis, agranulocytosis, etc. Allergic reactions produced by drugs administered orally are very similar to the reactions produced by ingested foods. Drugs, again like foods, are changed by stomach acidity, digestive enzymes and the intestinal flora. Most of the drugs causing allergic reaction are synthetic non-protein compounds and probably act as sensitizing agents only after chemical combinations with proteins of the body. In this way complex drug compounds undergo very extensive changes and the final product or antigen may bear no resemblance at all to the original drug, and may be an entirely different substance. This explains why skin tests with raw non-protein drugs are unsatisfactory and of little value. Drugs which primarily are proteins, of course could be expected to, and sometimes do, give positive skin tests in sensitized individuals.

Drugs of both types, protein and non-protein, or crystalloids, may cause the same sort of anaphylactic shock as will other antigens to which an individual may be sensitized, such as foods, inhalants, serum, etc. Such commonly used medicaments as insulin, vaccines prepared from egg yolk, liver extract, and many others, have at times caused severe anaphylaxis with dyspnea, cyanosis, urticaria and collapse.

It is advisable to proceed with caution in the administration of a new or untried drug to any patient who gives a positive history of other drug sensitizations or in the presence of a personal or family history of other allergic manifestations. If, for any reason, a drug comes under suspicion the best procedure is to forget about it and to use an unrelated substitute of a different class.

Proper Use of Epinephrine

I would like to add a further word concerning the use of epinephrine, or Adrenalin®. Although this is a very valuable drug, it also is a very powerful one, and it has been my observation that frequently it is used to excess and injudiciously. We should not hesitate to use adrenalin in full dosage, if necessary, but usually, and except in extreme cases, a dose of from 0.2 c.c. to 0.4 c.c. will bring about the desired results.

Some time ago one of my patients suffered a severe attack of asthma. She was unable to contact me and called a doctor nearly who gave her a subcutaneous injection of Adrenalin. The asthma promptly disappeared but other alarming symptoms developed. The doctor called my office and told my nurse that the patient was in great distress, that her heart was beating like a triphammer, that she had severe head pain and that she was very pale, shaky and agitated, almost to the point of convulsion. He asked the nurse what we had done for this patient in prior asthmatic attacks and when she told him that 0.2 c.c. of Adrenalin had always controlled the attacks, even severe ones, he groaned and said, "My God, I gave her a full c.c. If she dies they will find two corpses here instead of one."

Recently a small boy, six years of age, was rushed to my office. He was gasping for breath and suffering from a very acute and alarming attack of asthma. The nurse told me later that she was afraid he was going to die. She gave him 0.05 c.c. of Adrenalin and when I arrived a few minutes later he had recovered and was quite comfortable. The same dose was repeated, for good measure, before the boy started home although this extra dose probably was unnecessary. Adrenalin is a very useful drug, as we all know, but let's not overdue a good thing.

Usually the allergic individual consults his family doctor for relief of his symptoms. The general practitioner should be sufficiently "allergy-conscious" to at least suspect and consider the possibility of the presence of allergic disease when these patients come to his office. He can manage a number of these cases himself but if he is not prepared to carry out the minute details of diagnosis and treatment required in many instances, then he should refer the patient to a specialist in this field. If the patient lives so far away that frequent trips are burdensome, the allergist, after his initial examination is completed, very probably will ask the referring doctor to assume the management of the case and to administer such active treatment as may be prescribed, with only occasional visits back to the allergist for a recheck and such revamping of the situation as may be advisable. In my own experience, this arrangement has proved quite satisfactory. Through such cooperation the patient's needs may be satisfied, the allergist will be grateful and the family doctor may continue to look after his own patients' interests, which is, of course, as it should be.

Circle March 26 on Your Calendar!

County Society Officers Conference

(9:40 CDST)

Phoenix Hotel—Lexington

Spontaneous And Habitual Abortion*

Frank R. Lock, M.D.
Winston-Salem, N. C.

THE practice of obstetrics provides a great deal of pleasure and satisfaction to the physician. The results are usually excellent and the doctor-patient relationship is a pleasant and happy one. It is also a field in which major complications may represent medical tragedies. Because two individuals are involved, the entire future of a young family is often affected by an obstetric accident.

Although early spontaneous abortion rarely endangers the life of the mother, it represents a serious loss to the couple who have established the new member of the family in their emotions and planning. Habitual abortion is defined as the consecutive loss of three pregnancies. The disappointment related to one abortion is multiplied many times with each repeated fetal loss and a discouraged or hopeless attitude may develop concerning childbearing.

The medical literature abounds with scientific facts and recommendations concerning spontaneous and habitual abortion. Unfortunately, many controversial attitudes and contradictory statements appear. By limiting our knowledge to selected reports, or accepting the claims of commercial advertisers, one might assume that little or no problem exists. However, we cannot defend such a position and must review and appraise the established facts from time to time.

Incidence

The incidence of spontaneous abortion is approximately 20 per cent. Mall[1] and Taussig[2] place the figure as low as 10 per cent, but Malpas[3] and Meyer[4] found the frequency to be 18 and 22 per cent respectively.

In an analysis of 6,000 pregnancies, Malpas showed statistically that after one abortion the chance of subsequent loss of pregnancy was 22 per cent, after two successive abortions 38 per cent. Although his experience indicates a 73 per cent loss after three consecutive abortions and 94 per cent after four, other observers do not confirm these statistical figures. However, the importance of searching for etiological factors which may be corrected prior to subsequent pregnancies is indicated by this experience.

**Presented at the general session of the Kentucky State Medical Association Annual Meeting, September, 1958.*

Pathology

Pathological studies of abortions show abnormalities of the products of conception in a high percentage. Hertig[5] found that 46 per cent of his series of abortions were due to blighted ova, Mall and Meyer found 48 per cent, Javert[6] 35 per cent, and Colvin[7] 20 per cent abnormalities. In addition, Hertig found that 90 per cent of all spontaneously aborted products had conditions incompatible with further development of pregnancy. Streeter observed that death of the embryo usually occurs six weeks before expulsion of the products of conception from the uterus. This has been confirmed by Hertig and others who found the embryo developed six weeks less than expected for the duration of pregnancy at the time of abortion. Therefore, treatment of any type cannot change the results in a significant number of patients. It is unfortunate that the facts outlined above have been described as representing "abnormal germ plasm." Consequently, many couples have abandoned hope of a family because it was implied that one or both of them produced abnormal reproductive cells. Since many conditions affect growth and development of any living organism, this may be false.

Considering pregnancy with an attitude comparable to the approach to the production of farm products or specimen flowers is helpful, since it reflects basic biologic facts. In each instance, seed, soil, and adequate nutrients for growth and maturation are essential. Regardless of the quality of the seed, little is expected when it falls on barren and unprepared ground. Ideally prepared soil will grow plants which characterize the seed which has been planted. Unless water, sunshine and basic mineral requirements are met through the period of growth and maturation, the results are invariably disappointing. Fetal loss, considered in the categories outlined above, explains early and late abortion. In habitual fetal loss similar or identical responsible conditions are apt to be present.

The etiological factors related to spontaneous and habitual abortion may be considered in three major categories:

1. General metabolic states

2. Psychiatric and emotional considerations, and
3. Genital lesions

Metabolic Lesions

Tangible—Intangible

Emphasis must be placed upon thorough evaluation of the overall medical status of the couple in all cases of abortion. There is a general tendency to focus primary attention on the genital system, however, infertility and abortion occur frequently in the diabetic, and those with abnormal thyroid function. In debilitating diseases a low index of fertility is common. It is fortunate that spontaneous abortions occur frequently in renal disease and other medical conditions which are often adversely effected by the physiologic demands of pregnancy. The extensive pathological changes in the placenta in renal disease which produce fetal death are well known.

In the human little is known of a specific relation of diet to reproductive efficiency. It may be assumed that dietary deficiencies represent intangible factors in spontaneous and habitual abortion since specific dietary restrictions will consistently produce infertility and fetal loss in experimental animals. However, publications in this area relative to the human are not conclusive.

Psychiatric and Emotional Factors

The documentation of organic changes in the reproductive system resulting from psychiatric disease is often difficult. That menstrual function may be profoundly effected by emotional tension is generally known, and increasing numbers of reports of pelvic pain and other functional abnormalities related to psychiatric lesions are appearing in the literature. Marked variations in the quantity of spermatazoa have been proven under various states of stress.

The relationship of psychiatric disease to abortion is a relatively new field of investigation. The studies conducted by Edward C. Mann[8] and his associates at New York Lying-in Hospital, and those of Javert, are most convincing. In a few of the patients with direct psychiatric causes for abortion the relation is obvious, and repeated abortion occurs on the anniversary of a criminal abortion or some severe emotional experience. However, such information is rarely elicited in an ordinary medical history, and obscure psychiatric information is almost never obtained. It is impractical to arrange psychiatric studies of every couple presenting the problem of habitual abortion, however, awareness of a cause-effect relationship between psychological and emotional factors and abortion may be helpful to the physician in charge of any patient.

Genital Pathology

1. Uterus: a. gross pathology
   b. congenital lesions
   c. acquired lesions
II. Endometrium

Gross pathological lesions of the uterus are not common in the etiology of abortion. Retroversion and retroflexion of the uterus have been proven to have little or no relationship to abortion. There appears to be a definite increase in the frequency of abortion in patients with multiple uterine fibroids, but this problem is not common in the reproductive years even in the colored race. Other forms of pelvic pathology have a much more direct influence on fertility than on spontaneous abortion.

Congenital and acquired conditions of the uterus are conclusive causes of late abortion, but appear to have little influence upon the incidence of early spontaneous abortion. Only two conditions are found, one in each category.

Uterus didelphys, bicornuate or septate, is an infrequent cause of habitual middle trimester abortion. These congenital abnormalities usually require a hysterogram for their diagnosis, and this examination is indicated whenever there is a history of late abortion. In selected patients reparative operations are indicated.

Recently, studies by Lash[9] and Barter [10] have increased the emphasis on incompetence of the internal os of the cervix as a cause of late abortion. This condition seems to be acquired through traumatic delivery or surgical procedures in all patients. It is suggested by the history, and confirmed by the observation of progressive effacement and dilatation of the cervix during the course of pregnancy in absence of labor. Accuracy of the preconceptional diagnosis of this condition may be increased by a new technique of x-ray visualization described by Mann.

For growth and development of any living organism, a satisfactory environment is essential. A regular and normal menstrual cycle is often presumed to be evidence that regular ovulation occurs, and that the endometrium is normal. The studies of Hughes[11] and others have shown conclusively that qualitative and

quantative deficiencies in the endometrium are often present in relation to habitual early fetal loss. Decidual hemorrhage and deficient fetal development may logically follow implantation in such deficient soil. Preconceptional endometrial studies will often reveal consistent endometrial deficiency in patients who have had habitual abortion. The cytological characteristics and differential qualitative staining are used for evaluation of the adequacy of the endometrium for conception and successful development of the fetus.

Management

Spontaneous abortion—habitual abortion

The satisfactory management of spontaneous and habitual abortion depends upon a complete and accurate diagnosis. When a woman is seen with the presumptive diagnosis of abortion based on a history of bleeding after a period of amenorrhea and early pregnancy symptoms, it is essential that a pelvic examination should be made. There is little or no evidence that gentle pelvic examination will precipitate or encourage the progression of an abortion. On the other hand, large numbers of women are subjected to psychic trauma and extensive medical treatment when pregnancy has never been present.

The examination should consist first of inspection of the cervix with a satisfactory speculum and a good light. Dilatation of the cervix, rupture of the membranes, or very profuse bleeding indicates an inevitable abortion is present. The presence of products of conception in the cervix represents incomplete abortion. All active bleeding should stop when an abortion is complete. A bimanual examination should be employed to confirm the diagnosis of intrauterine pregnancy, and the possibility of ectopic pregnancy must always be considered.

Colvin's studies indicate that the type of bleeding is of prognostic value. Of 452 patients in whom the initial bleeding was brown in color, 55 per cent aborted. In only 5 of his cases did brown bleeding appear as an initial symptom in the second trimester of pregnancy. In more than 1,000 cases where the initial bleeding was bright red, often of considerable amount, only 10 per cent aborted and 87 per cent continued to term.

In his review of the salvage possibilities in 1570 consecutive cases of threatened abortion, 70 per cent continued to term upon a program of management which included no direct treatment of the condition. It is his practice to offer a simple explanation of the background of early abortion to satisfy the patient with this approach. Reasonable activity is permitted as to meals and bathroom privileges. If the pregnancy is less than two months, the patient is allowed to remain at home, and more advanced pregnancies are admitted to the hospital. No advantage has been found in prolonged bed rest. If evidence of inevitable or incomplete abortion is present, oxytocics are administered, and unusually free bleeding is controlled by intravenously administered Pitocin.® The products of conception are allowed to be expelled spontaneously unless found to be hanging loosely in the cervical canal, when it may be simple to lift them out.

Our plan of management coincides exactly with that of Colvin.

There is much to indicate that little or nothing is gained by the administration of hormones, vitamins, minerals, or other drugs to the patient with threatened abortion.

It is unfortunate that no clinical method for detection of viability of the embryo is entirely satisfactory. Our experience and that of Colvin has been that an evaluation of symptoms and observation of presence or absence of growth of the uterus gives a fairly high percentage of accuracy. We wait for spontaneous termination of pregnancy when a diagnosis of missed abortion is made.

Habitual Abortion

Evaluation of habitual abortion presents an entirely separate and distinct problem, and every effort should be made to determine some specific factor which may have contributed. All studies are made in the interval between pregnancies, to permit preconceptional correction of any etiologic factor.

A search for paternal factors is of equal importance to the maternal studies. Each of the etiologic conditions which have been reviewed above is surveyed. Although the result of these studies may be primarily psychological when no abnormality is found, the patient enters subsequent pregnancy with much more satisfaction. These patients are encouraged to maintain a conservative equilibrium concerning the result when pregnancy is undertaken. It is very gratifying to find a specific etiologic factor which can be corrected. Under these circumstances, patients may resume their ef-

forts to have children with reasonable assurance of success.

Summary

Spontaneous and habitual abortions are responsible for the loss of more babies than any other cause. A review of the current literature has been made and a brief summary of established facts and certain opinions relative to spontaneous and habitual abortions has been presented. It is noteworthy that a tendency has developed to investigate the etiology of these conditions. The problem will no longer exist when prophylactic measures are available which eliminate the cause for abortion in each case.

Little can be accomplished by treatment initiated after the processes of abortion appear, and equally as good results are obtained by simple supportive measures as with intensive medical treatment.

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The Changing Picture Of Dementia Praecox*

DONALD M. HAMILTON, M.D.**

White Plains, N. Y.

DEMENTIA praecox is a medical problem whose socio-economic importance dwarfs almost all other medical problems. Each year this blight strikes down about 45,000 of our youth and young adults. Under the best of treatment now available almost one half eventually become so involved that permanent hospital care is necessary. Too many of those who return home are semi-invalided and unable to share productively in the work and pleasures of living.

At the present time almost one third of the admissions to The New York Hospital—Westchester Division in White Plains, New York, suffer from dementia praecox. Over the past 30 years it has been interesting to note certain differences in patients at the time of admission. Patients are now coming to the hospital earlier in the course of this illness. More are accepting their need for treatment and enter voluntarily. The symptoms displayed at the time of admission are not so dramatic and obvious as in the past. It is not uncommon for the admitting physician now to have to ask which is the patient and which the relatives.

At least three important factors have helped to bring about this change:

(1) The medical school curriculum provides more adequate training in psychiatry. More general hospitals provide in-patient and outpatient services for the treatment of psychiatric disorders. The psychiatrist is now more commonly a part of the medical treatment team in general hospitals. This has resulted in earlier recognition and earlier treatment of mental illness.

(2) The Mental Hygiene movement has helped break down barriers of stigma and guilt which made many patients and their relatives hesitate to seek treatment. Communities with active Mental Hygiene programs provide better facilities for treatment and the facts concerning mental illness are more widely spread before the community.

(3) Modern psychiatry has more to offer patients. The shock therapies and tranquilizers appeal to patients and relatives. Here is something tangible being done which results usually in early signs of improvement. Patients and relatives are then better prepared to accept the more significant results to be obtained by prolonged psychotheraphy. We have greater understanding of the meaning of symptoms presented by patients so our psychotherapeutic approach can be more rational and planned. In a modern psychiatric hospital there is more opportunity to regain the art of living through psychotherapy and a well balanced program of activities. Hospitalization, though more expensive, is of shorter duration and results are better. Even in dementia praecox 50% more now return to life as vigorous and productive members of society. They are often better prepared and more efficient in handling life than they were before their illness.

In present hospital practice we seldom see the mute, rigid catatonic, requiring tube-feeding, who suddenly breaks out into episodes of wildly excited, impulsive behavior. Rarely found is the paranoid patient, loudly denouncing his imagined persecutors, or else, in a superior, detached manner, living out his imagined identification with the deity.

What we do see, instead of these reactions (and certainly catatonic and paranoid reactions have not suddenly disappeared) are reactions in which anxiety, hypochondriasis and rebellious "acting out" behavior, the latter remininescent of the psychopathic personality, predominate. Acting out is a phrase used increasingly in psychiatric discussion and has come to suggest psychopathic-like acts. Certainly psychotics have always "acted out" but in the past perhaps more in a highly symbolized manner which may have communicated less meaning as to what the activity really meant to the patient.

At White Plains the history of recently hospitalized dementia praecox patients more frequently than in the past records hostile, threatening tirades, open flaunting of conventional attitudes towards property of others and sexual mores, including sexual assaults, as well as non-sexual assaults on family members and

*Presented before the Kentucky Psychiatric Society during the KSMA Annual Meeting on September 24, 1958.

**From the clinical service of The New York Hospital—Westchester Division, White Plains, New York. James H. Wall, M.D., Medical Director.

others. In the past such actions before hospitalization were not as common, although impulses towards such behavior could be recognized in highly symbolic behavior or were expressed in phantasies or dreams.

Of particular interest is that such behavior is now seen more often in a relatively clear setting and not in one of marked and consistent excitement.

It is the impression of many of us on the staff of The New York Hospital—Westchester Division that such symptoms are often an expression of a tragic lack of maturing of a conscience or super-ego and not so much a regression or narcissism and infantile patterns. A patient treated in the 1920's in bizarre activity pantomimed the alternate burial of her father and her husband as she struggled with a decision concerning her marriage. She recovered after making a healthy choice and returned to her husband. Over 20 years later her son, 17, exposed himself openly on the school grounds at recess. He was brought to the hospital where he was found to be in a catatonic turmoil struggling with forces of good and evil and quite conscious of sexual strivings towards his mother. He also recovered and has completed high school and college and is now married.

It is a group of young men, like the one mentioned above, ranging in age from 13-22, that have made up an increasing proportion of our admissions in recent years. It is this group which furnished the experience for this discussion.

These young men, as a group, have developed through infancy and childhood in a cultural setting which, though typical of this generation, is unusual compared to preceding generations.

Since the 1920's parents have been under rather bewildering and sometimes tragic pressures from our culture. They have been strongly criticized and even condemned. First there was the era when parents were seriously admonished in authoritative books to be unresponsive to their infants' needs for affection and comfort, particularly if sons. A rigid and emotionally sterile schedule was outlined which provided good techniques for the child's physical needs but overlooked his emotional needs. To saddle your son with an Oedipus complex became so frightening that some parents became frozen and reacted to their children with less warmth and display of affection than they gave the family pet.

In the 1930's the pendulum swung in the opposite direction. Parents now were advised to be all giving and endlessly permissive. Aggressive activity in children whether expressed in unusual wetting and soiling, verbal or physical assaults or destructiveness was condoned as needed "self-expression" not to be inhibited if you wanted your child to become a healthy, extroverted "go getter" of an American citizen as an adult.

At the present time we are returning to efforts at control. Spanking is coming back in fashion. Attitudes towards juvenile delinquents too often smack of sadism than a concerned interest in helping.

Underlying the philosophy of parent and child relationships through this past 30 years has been what is, to many psychiatrists, a pernicious and unrealistic dictum that "There are no sick children, only sick parents." Many parents come to psychiatrists bewildered and paralyzed by feelings of inadequacy and failure. The therapist finds history taking difficult because of parents' reactions of defensiveness and projection as they try to defend themselves from what they believe will be a critical, judging response on the psychiatrist's part.

Another dictum of psychiatric thinking for the past generation has been "Give me the child until the age of 5 or 7 and I will make the man." There is no doubt that experiences in infancy do influence personality patterns in later life. But our experience as psychiatrists teaches us also that personality patterns are modifiable in any stage of life. We corroborate this daily in our treatment of patients. In our fascination with infantile development we have tended to under emphasize the value of parental interest and guidance throughout the years of childhood and adolescence. Parents under the misguided influence of the belief in the all importance of infancy, have, in our experience, too often abdicated from their role of guidance and responsibility in the childhood and adolescence of their children with tragic results.

Infancy is only one era of arduous challenge for parents. Childhood, adolescence and early adulthood are also periods when our children also need and expect much help. A wise friend of mine admonished me tactfully when I remarked I was looking forward to the period when my children were teen-agers so I could

rest and have more time to do what I wanted to do. His reply was, "Well, I found out that at least when my children were in adolescence I could do my worrying sitting down. I didn't have to chase around after them."

The present generation of adolescents we are seeing in hospital treatment were war babies. Typically they were born when the father was away from home in the armed services for a 2-3 year period. During this period there was no real father figure in the home. Although the pregnancy was usually planned in a happy setting for both parents, mothers were tragically ambivalent about the child after birth. The mother, living alone, or crowded into a home with grandparents, felt lonely and unappreciated. The needs of the baby and work connected with supplying him were a source of great irritation when not balanced by the comforting support of a husband. This was particularly true if the child was the first born. Many young men grew up in a feminine environment, over-indulged and often subtly rejected as well.

The father's return from service was frequently anything but a happy home coming. He had come from the disciplined life and rigidity of a male armed service experience where the manly virtues of being "able to take it," of being outgoing and aggressive were emphasized. He arrived home to an infant son, 2-5 years old, frightened and shy of the stranger father, often crying at the unfamiliar loving roughness of the father's response to seeing him and clinging to the mother. Fathers frequently responded to this experience by seeing their sons as "sissies" in the making, badly spoiled, and reacted harshly to both the child and the mother. Many mature fathers in my experience have commented how difficult it has been to develop deep tender and paternal feelings towards the child born when he was in the service. Fathers and sons in these circumstances often remained strangers to one another living together in a tense, armed truce. Later children born in a more normal family setting in place and time attract more usual tender and warm responses from the father and are consciously and unconsciously favored by the father as well as by the mother. The older child senses this as a rejection and a difference in himself which he may react to by feeling he is unlikable and build up defensive mechanisms. In our patients this was a not unusual background for psychiatric disorders developing in the teens.

A 14-year-old boy was admitted after an attempt to strangle his younger sister. He carried the same name of his father and grandfather who were both successful physicians prominent in the community where he was living at the time his illness began. His father, an over-conscientious man, with rigid patterns, had not seen the son until he returned from service when the son, the first child, was 2½ years of age. The patient had been born when his mother and her parents were distressed at news that the mother's brother was missing in action. Later it was learned he had been killed. The mother and grandparents were distraught. The patient cried constantly for six months and was a feeding problem. His mother "never liked him" and favored the two daughters born after the father's return from service.

The father returned from service and found what he interpreted as a spoiled cry-baby, a sissy, and in order to toughen up his son, he struck him repeatedly across the face so that for years the patient cringed whenever his father raised his arm. In a college psychology class the father came to realize his reactions were not healthy and made a sustained effort to achieve a better relationship. When the patient was 7, such a relationship was obtained and remained on a good level until the setting of the present illness. At 14 the patient put his energies into sports and made a high school football team, gaining much status with classmates of both sexes. However, in his concentration on athletics, his A average in his studies fell to B. The father, anxious to have a third generation physician in the family, told his son he could not play football until he had A in all subjects. When his son remonstrated strongly, the father impulsively struck his son across the face. The patient, stunned, did not move and quietly said he would accept his father's decision. By the next morning he was bewildered as everything happening seemed to be directed to help him along in life. While sitting in the living room playing with his sister, he suddenly attempted to strangle her. He is now under treatment for a catatonic dementia praecox.

However, it is necessary to realize that not all children respond with mental illness in such a background. The vast majority are able to make some healthy form of personality integration even though they tend to deviate more

commonly away from the average than other children in the family.

As psychiatrists we see individuals who develop mental illness in such settings. How often do we concern ourselves with the vast majority of young people who surmount these pressures and maintain their mental health? Certainly when we have a broad point of view it is difficult not to accept the belief that there are differences in resistance of individuals to psychological stress just as there are difficulties in resistance to physical stresses.

In such settings of human and tragic problems, it is easy for us to blame parents when we come to face the problem of a sick child years later; years after a series of inadequate responses to life experiences on the patient's part have culminated in dementia praecox. During these years parents, in our experience, have usually made efforts to help the patient and their efforts have been met time and time again by frustrating failure on the child's part. Certainly by the time the child and parents appear for treatment many parents are reacting inappropriately to the patient's needs. But the patient's needs at this stage are specialized and beyond the training and experience of the average parent. It is true that some parents have never achieved personality maturity and have never been able to respond with understanding and objectivity to their children's needs. But most, in our experience, have done their best and made a good effort in situations well beyond the average parents' capacities. If we blame parents for psychosis in a child we should also give them credit then for the health of the other children in the family who have been able to sustain their mental health through periods of marked stress. Parents of children with dementia praecox need support and often formal psychiatric treatment. They need encouragement and reassurance and certainly an attitude from the psychiatrist of understanding, not judging criticism. Psychiatrists who have themselves brought up their own children through adolescence ordinarily do not find it difficult to adopt healthy and realistic attitudes towards other parents struggling with a child who becomes ill in meeting the problems of the teens.

The incidence of dementia praecox patients who display hypochondriacal symptoms has been emphasized by Hoch & Polatin of the Psychiatric Institute in New York City. This type of reaction has been given the name of pseudo-neurotic schizophrenia. In spite of the good impression such patients make on first meeting, as they are alert, responsive and communicative, the underlying paucity and bizarreness of their emotional life, the relative lack of sustained drive and ambition found on closer examination and observation all speak for a serious mental illness. Early recognition of such pseudo-neurotic reactions as dementia praecox is an important step toward salvaging this group who otherwise have as poor a prognosis as other reaction types.

The following is an illustrative case history.

This 22-year-old man was admitted in January of 1956 for treatment because of migrating pains in his shoulders, arms, low back and legs of three months duration.

The paternal grandfather deserted when the father was 10. The grandmother was a strong figure. The father was a successful song writer and vaudeville performer. In the home he was self-centered, arrogant, and hot tempered. The mother was a small, charming woman who adopted a childlike but seductive approach when with her son and other men. An older brother was successful as a movie executive. In his teens he was irresponsible and psychopathic but later settled down.

The patient was the third of four children and was noted to be hyperactive even before birth. He was brought up by an irritable and suspicious governess who was angrily possessive of the children and instilled much fear in them, particularly towards the father. In infancy the patient preferred girls and chose girls' toys. He was teased by his older and more aggressive brother. He was distant with his father and close to his mother and liked to comb her hair. When 12 he was shocked when his older brother impregnated a girl and married at 16 precipitately. At 14 he started masturbating with homosexual phantasies and since 15 had been actively homosexual. His father refused to give him an opportunity for a college education and at 18 he enlisted in the army. In the military police he made a good record and was honorably discharged at 21. He then started to work in advertising, attracted by the glamour of the work. Self indulgent, he looked for a good time with a minimum of effort, and spent much time at a country club where he was an outstanding tennis player with friends much better off financially. His reac-

tions with people emphasized patterns of joking charm and submission.

His present illness developed in the following setting. He had been promoted in his work and found his immediate superior was a woman. He had recently moved into an apartment. His room mate was engaged to a good friend of his. With this room mate the patient conducted himself like a house wife, taking full responsibility for the meals and housekeeping. He was upset when his room mate became increasingly irritable and rejecting with him. In November 1955 he suddenly developed a feeling of stiffness and pain in the back of his neck. The pain came on suddenly and intensely, particularly at night, lasted 1-2 hours, and then suddenly faded. Gradually the pain included his shoulder muscles, lower back and finally his legs. Insomnia became the patient's greatest complaint. The complete neurological work-up revealed no organic pathology. A variety of medications and two months of psychiatric interviews did not help. When his parents became exhausted spending the nights to tend to his needs, hospitalization was arranged.

On admission his mental status revealed a rather awkward man with effeminate mannerisms. He lounged on his bed in a seductive manner during interviews. He expressed "great concern and panic" about not sleeping, in a bland and detached manner. He withdrew into his room, lying on his bed in quiet preoccupation. When patients came into his room, he encouraged them to massage his legs. In interviews he talked in great detail of his migrating pains, his insomnia; avowing complete cooperation with his physician while seeking at the same time to control his activity and medication dosage. He whined in seeking help from the physician, yet stated, "I don't think there is a thing that will put me to sleep." He often displayed a pouting petulance during which he sucked his finger. He blandly described his homosexuality and said, "I'm homosexual. That is it. I'm not here to change that." Sensorium, mental capacity and grasp were above average. His insight was poor and judgment impaired.

Psychological tests stressed a feminine orientation with fear of males and tension with females. Bottled up affect with explosive capacities was noted. Fear of rejection was pronounced. The diagnostic impression was an early catatonic dementia praecox.

Physical examination, including neurological, was essentially normal except for arthritic, flat feet for which special shoes were provided. Blood cytology, serology, chemistry and repeated urinalyses, chest X-ray, EEG were all normal. Repeated neurological examinations by consultants were essentially normal.

Course in hospital: Thorazine® and prolonged baths ordered on admission resulted in no improvement. He remained withdrawn, complaintive, displaying much passive resistance to help and much ambivalence in all relationships. A course of 11 E.S.T. in late January aided him to increase his activities and attend occupational and physical education activities which he performed in a desultory way.

In February 1956 he was able to enter into discussions of his attention-getting maneuvers on the hall which he related to his hostile competitiveness with his brother whom he felt his father and governess preferred. Following these discussions he became sarcastic and more openly hostile to other patients and at the same time enjoyed playing the piano while others sang. Investigations of his fear of male authority resulted in criticisms of his father in interviews and some hostile responses to his father when visited. In discussing his reactions with women, he became aware of fear of his passive and dependent needs. In April he was able to discuss his fear of growing up and saw the role of his not walking because of leg pain in keeping him like a baby. At this time all medications were stopped. He responded by putting in his notice to leave the hospital and making a homosexual approach and overt expression of hostility toward the male physician. When he refused to retract his notice to leave the hospital, he was certified to the hospital. After his certification his improvement was rapid. In the early summer he began making visits away from the hospital and surprised himself and his parents by his ability to speak up to his father in a natural manner. In October 1956 he obtained a position in New York City, commuting to work from the hospital at first, later spending weekends at the hospital and living at home during the week. While at home he did volunteer work at a settlement house one night a week. In December 1956 he left the hospital. Continued contact with the patient at intervals has been maintained. He now has his own apartment with a room mate with whom he has worked out a realistic, practical relationship, without being too submissive.

A New Treatment Service For Alcoholics*

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Introduction

ALCOHOLISM constitutes a major health problem. According to Noyes,[1] five out of six alcoholics are men between the ages of 30 and 55—the most productive years of life. It is estimated that there are approximately five million in the USA in whom drinking has an adverse effect on their lives in one way or another. During the fiscal year 1956-57, 10% of all newly admitted patients to Western State Hospital were alcoholics. They were hospitalized usually five to ten days in order to shorten their "drying out stage" and were discharged as soon as their physical imbalances were corrected. Practically no consideration was given to the psychological and sociological components which are of prime importance in this very complex disorder. In fact moralistic implications have interfered with the development of a scientific understanding and rational management of alcoholism.

With the establishment of an alcoholic treatment and rehabilitation unit at Western State Hospital in October 1957, and the recent formation of the Kentucky Commission on Alcoholism it is hoped that alcoholism will be no longer conceived as a moral problem but as a medical one, namely—in its last analysis—as a symptom of a mental or emotional disorder. It is not the quantity of alcohol consumed but rather the role which it occupies in the individual's adjustment to life that marks him as an addict.

Classification

According to Fox,[2] the alcoholic is classified as 1. Symptomatic drinker, 2. Primary addict, or 3. Secondary addict.

1. The symptomatic drinkers are the fewest numerically. They are the persons whose drinking is secondary to some well-defined emotional or mental disorder. Drinking is usually one of many symptoms and may actually be quite superficial. Needless to say, these psychotic and/or organic cases are referred elsewhere in the hospital for appropriate treatment.

2. The primary addict is one whose drinking is also determined by emotional factors but he differs from the symptomatic drinker in that he has no other demonstrable signs of mental illness. He is usually an inadequate, immature person whose emotional development was unhealthy from infancy or childhood on. Drinking usually started early and it seems that only through the use of alcohol can he achieve a state of emotional satisfaction. He constantly seeks relief from the tensions induced by anxieties, frustrations and conflicts. He is unable to compete with equals or superiors without feeling extreme anxiety. Or, he has difficulties in identification with his own sexual role, experiencing unusual fear of contact with those of the opposite sex. In short, alcohol allows him relief, whatever his problem may be. Later, he becomes remorseful and feels guilty for his behavior. He then craves more alcohol in order to relieve this guilt. The more he drinks the more guilt he feels. The more guilt he feels, the more he drinks until a vicious cycle is initiated. His own sense of unworthiness is apparently confirmed by family, friends and employer, who begin to use punishment, threats and withdrawal of affection and approval. This unbearable state is then drowned out by more alcohol.

3. The secondary addict usually is a person whose drinking has generally become a problem only after years of excessive social drinking. He frequently gives a history of formerly good adjustment in marriage, work and social life. Usually however, a more careful study will reveal that neurotic conflicts were present before he became alcoholic. His neurotic defenses allowed him to function in an apparently normal manner. Secondary addicts have a much better prognosis in treatment than primary addicts, provided they come for help before the mental and physical changes become irreversible. As they had once attained a fair degree of adjustment, they have something to return to in sobriety. The primary addicts, however, never having learned the techniques of living, have a much harder time of it.

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**Since this article was received for publication the author has become Clinical Director of Eastern State Hospital, Williamsburg, Va.

Procedure

This special unit for the treatment of alcoholism consists of two sections; a closed ward with a capacity of 39 beds and an open ward with 21 beds, a total capacity of 60 beds. Due to the complex nature of alcoholism, the team approach is the most expedient choice. A Psychiatrist, a Chaplain, a Social Worker, a Nurse, and two Psychiatric Aides are the members of this therapeutic team; they are strongly supported by an Industrial and Occupational Therapist, Recreational Workers, as well as Volunteers and A. A. Members. The great majority of patients are admitted under the newly enacted alcoholic commitment law (June 1958). The average length of hospitalization ranges between 35 and 40 days. The patient is admitted to the receiving or infirmary ward, according to his physical condition; needless to say, somatic therapies (intravenous fluids, vitamins, tranquilizing drugs) are in the foreground during the initial stage of hospitalization.

Usually within 5 to 8 days following the restoration of the patient's physical health and completion of diagnostic studies he is transferred to the closed section of the special treatment unit. Due to the specific sociodynamic patterns which exist in the problem drinker, the treatment there is focused on group psychotherapy. The group meets twice weekly for one hour each session. The sessions are for the purpose of finding solutions to the problems of the alcoholic. Important dynamics of the therapeutic process can be stated, as outlined by Brunner-Orne[3] in the following terms:

1. The group provides substitute emotional satisfactions to the patient. This is particularly true in light of the ever present guilt in the drinker due to the strong instinctual drives, both aggressive and sexual, which are lived out under the influence of alcohol, either actually or in fantasy.

2. The feeling of psychological isolation so characteristic of alcoholics is materially decreased.

3. It is made possible for the patient to accept the fact that he is an alcoholic and that there are other "nice people" who share this problem.

4. The patient is forewarned by the group against many of the rationalizations which are so popular with alcoholics.

5. The fact that group conclusions arrived at by free discussion exert a potent effect on the individual is well known and is utilized in prompting the idea that sobriety is not only desirable but attainable.

This type of therapy is combined with pastoral counseling, social casework, and weekly A. A. meetings on the ward. In relation to work with alcoholic patients, pastoral counseling has as its chief objective the establishment of rapport with patients by the Chaplain so as to help the patient to regain his sense of self-acceptance from a religious framework. Social casework is focused on the patient's relatives to gain a better understanding of his needs and on social planning for his future. A. A. often helps the patient with his fears, his sense of inferiority, and his isolation. The treatment program is further supported by Industrial and Occupational Therapy, Recreational activities, and Volunteer services. Volunteer workers who symbolically represent the community are very helpful in restoring the patient's feeling of social worthiness. Particular emphasis is placed on Industrial Therapy. The patients are assigned to carry and distribute food to the chronic wards, wash dishes, and clean these wards. This type of activity allows them to regain a sense of usefulness for others thus raising their self-esteem. Also, since they are thus exposed to patients with organic brain damage associated with alcohol intoxication, they have an opportunity to realize how harmful continued and excessive drinking might be.

From the closed ward on which he usually spends fifteen to twenty days, the patient is then transferred to the open ward. The various forms of therapy are continued but in a less controlled fashion. Due to his regaining of freedom, his right to choose, the patient is then allowed to select his Industrial Therapy assignment according to his skills. He also is free to choose various types of group activities such as attending the downtown A. A. meetings. The patient usually spends approximately two weeks on this open ward. Some patients escape; the hospital, of course, does provide security to prevent the elopement of patients who do not know what they are doing, but the hospital cannot and will not set up jail-like security which will prevent carefully premeditated escapes. The alcoholic patient is not declared incompetent at the time he is committed.

Most patients are released and referred to A. A., others request their discharge or their

relatives, particularly masochistic wives, insist upon their release, others remain for a while longer and some don't want to leave at all, particularly in the winter time. Others become intoxicated again shortly after their release and are brought back or return voluntarily to the hospital. Others stay sober and visit the unit to bring cigarettes to the patients. Others eagerly join an already existing A. A. group in their locality. Some try to organize a new group, realizing that a strong identification with the group might keep them sober. The motivations of the alcoholic patient during this last stage of hospitalization or following his discharge are indeed manifold.

Results

From October 1957 until September 1, 1958, 186 patients were admitted to the alcoholic treatment unit. The first 75 discharged patients were re-evaluated (by questionnaire) after three months. Approximately ⅓ remained sober, ⅓ continued to drink, but less excessively, and ⅓ relapsed into heavy drinking. Nine patients out of the latter group who were primary addicts were readmitted. Further re-evaluations and follow up studies are indicated.

Discussion

Only one staff member is on a full-time basis devoted to the treatment program. He is a Psychiatric Aide who graduated from the Yale Summer School of Alcoholic Studies. His training was sponsored by the Kentucky Commission on Alcoholism. The rest of the staff is participating in the program only part-time as they have various other duties in the hospital. More full-time personnel is needed.

The alcoholic commitment law was and still is misused. Referring agencies swamp the unit with poorly chosen patients who watch sullenly for the first opportunity to escape. Usually they have had the choice between jail and Western State Hospital. Naturally they choose the hospital. They display a total lack of motivation for rehabilitation and only dilute the limited treatment potentials of the unit, thus the Staff has no choice but to discharge them. A pre-admission evaluation concerning the willingness to undergo rehabilitation is indicated.

Treatment facilities for female alcoholics are inadequate as there is no unit for females.

Summary

Alcoholism is a treatable but an extremely complex disorder with not only psychiatric and medical aspects but social ones as well. It requires many types of therapies but most of all an informed public is needed. The Department of Mental Health and the Kentucky Commission on Alcoholism can take courage in the realization that satisfactory beginnings have been made at Western State Hospital. A short year ago we had almost nothing to offer whereas now the hospital has a basic treatment program which can be extended and improved.

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Sweat Gland Tumors

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DURING the past few years I have observed six cases of tumors of sweat gland origin. Since the differential diagnosis of subcutaneous nodules should include the possibility of this type of tumor as well as superficial verrucous and pigmented lesions, it is felt worthwhile to present a detailed account of these findings.

Anatomy

Knowledge of the anatomy of the sweat glands is important to the understanding of the nomenclature and histogenesis of these tumors. There are two types of sweat glands:[4] the eccrine or small sweat glands which are derived from the epidermis and the aprocrine glands which are derived secondarily from hair papilla and are found in the axillae, genital and anal regions, on the nipple and its areola. They evacuate cell plasma and detritus. It has been estimated that there are between 2,000,000 and 15,000,000 sweat glands over the body. The glands are situated in the subcutaneous tissues as a rule, with an occasional one in the deeper part of the corium.

Anatomically the sweat gland is divided into three parts. 1. The coil is the end of a tube coiled upon itself. The tube terminates in a pouch, which is lined by a single layer of nucleated epithelial cells. Outside of this tube are smooth muscular fibers which run parallel with or in a spiral direction about the coil. These cells are known as myoepithelial cells and contain myofibrils. Contraction of these cells causes sweat to be extruded. Surrounding the myoepithelial cells is a connective tissue membrane. 2. The coil duct leads from the coil to the epidermis. It is lined with a double layer of cuboidal epithelial cells. External to these cells is the membrana propria, which does not have muscle fibers. 3. The duct becomes a sweat pore when it enters the epidermis. Here the duct loses its cuticle and external connective tissue sheath. The pore is thought to be lined with its own epithelium.

Case Reports

1. R. E., a 34-year-old white male was seen on June 8, 1957 at which time there had been a growth on the right side of the forehead for the past thirteen years. He stated that it had not changed in size or color. It was excised by another physician one week before he was seen. A tumor on the right cheek was excised at the same time, which proved to be a basal cell carcinoma. Microscopic examination revealed two cysts adjoining each other. The cyst walls were lined by two rows of cells. The outer row consisted of cuboidal cells with deep staining nuclei. The inner row was composed of high cylindrical cells, which showed evidence of secretion. There were papillary projections from the sides of the wall into the cysts. These papillary projections and villi consisted of walls with two cell thickness. The microscopic picture was consistent with syringocystadenoma papilliferum.

2. E. H., a 71-year-old white female was seen on November 12, 1957 at which time there had been a growth above the right nipple for three years. The lesion had been getting larger slowly. On physical examination there was an elevated verrucous pigmented lesion 0.5 cm. in diameter just above the right nipple. The clinical impression was melanoma and the lesion was excised. Histological examination revealed several small cystic areas immediately below the epidermis. The walls were lined by two rows of cells: the outer row had small dark staining nuclei and the inner row tall columnar epithelium. Within the space were numerous papillary projections covered with a similar type of epithelium. There was plasma cell infiltration of the surrounding tissue and also the papillary projections. The lesion was diagnosed as syringocystadenoma papilliferum.

3. J. B., a 59-year-old white male had had a growth on his right cheek for thirty years. The lesion more than doubled in size since it was first noticed. He was first seen on December 3, 1957. Physical examination revealed an elevated pearly lesion involving the right cheek, which measured 0.8 cm. in diameter. The clinical impression was squamous cell carcinoma. The lesion was excised and pathological examination revealed a varied appearance. In one place there was marked hyperplasia of the epidermis. The cells were of the



Fig. 1

Case 2. Syringocystadenoma papilliferum. Two dilated cysts are seen with openings through the epidermis. Lying in the cysts are many villi. Deep in the dermis are dilated apocrine glands.

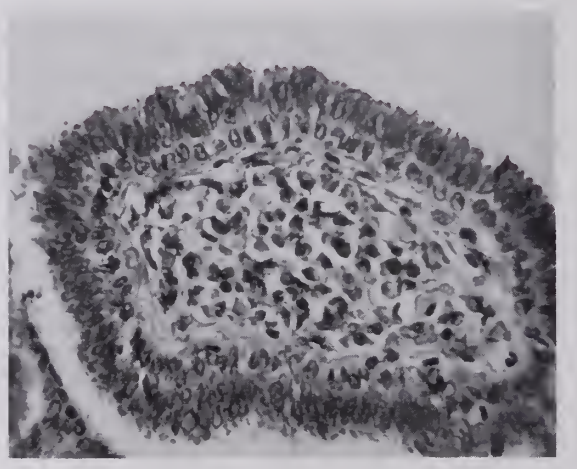


Fig. 2

Case 2. Syringocystadenoma. A villus showing two cell types lining the wall. The outer cells appear to be actively secreting. The inner cells have dark staining nuclei and are myoepithelial cells.

squamous type and were well differentiated. The granular layer was preserved and the keratohyaline granules were very coarse. Adjacent to the nodule there was a cleft lined by a wall with two cells. There was a papilla lined with two cells of sweat duct type. The microscopic picture was consistent with syringocystadenoma papilliferum and keratoacanthoma.

4. C. M., a 49-year-old white female was seen on July, 1952. She stated that there had been a growth on her back for the past eighteen months. There had been no soreness or tenderness and it had never drained or been infected. On physical examination there was an indurated lesion 0.5 cm. in diameter overlying the third thoracic vertebra. The impression was a sebaceous cyst and the lesion was excised. Pathological examination revealed cyst-like spaces lined with epithelial cells. Surrounding these were sheets of cells which were large and foamy. Some hemorrhage was present. A diagnosis of myoepithelioma was made.

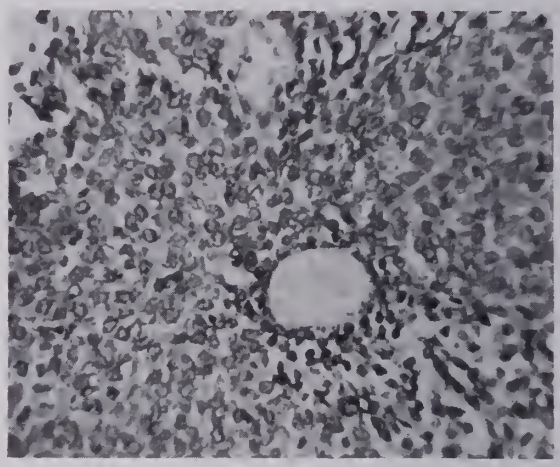


Fig. 3

Case 4. Myoepithelioma. There is a lumen lined by cells with dark staining nuclei. These cells appear to be actively secreting. Peripherally there are sheets of pale round cells which are myoepithelial cells. There is mucinous material between some of these cells.

5. C. L., a 30-year-old white male was seen on August 19, 1957. He stated that there had been a growth on the left side of his upper lip for four years. The lesion had grown rapidly since it was first noticed. Physical examination revealed an elevated hard lesion 3 cm. in diameter involving the left side of the upper lip. It was not bound down to the overlying skin. The clinical impression was infiltrating squamous cell carcinoma. The tumor was encapsulated and easily excised, cutting like cartilage. Microscopic examination showed a nodule in the cutis consisting of a variety of tissues. There were irregular ducts lined by a double layer of epithelium, loose fibrous tissue which in places was myxomatous or chondroid, and occasional fat cells. The lesion showed changes consistent with a mixed tumor of the skin.

6. B. A., a 69-year-old white male was first



Fig. 4

Case 5. Mixed Tumor. There is an elevated tumor involving the left side of the upper lip. There are telangiectases over the surface of the lesion.

seen in January, 1957. At that time he complained of a growth of his skin of three months' duration. Previously he had had many solar keratoses and squamous cell carcinomas removed from his face. Physical examination revealed an elevated pearly tumor 2 cm. in diameter involving the skin overlying the left mastoid bone. The impression was a squamous cell carcinoma. The lesion was excised and examination showed a tumor composed of many cysts lined with columnar epithelium. In other areas there were several layers of epithelium which had the appearance of squamous cells. The centers of these spaces contained desquamated cells of squamous epithelium which were partially or completely keratinized. In larger spaces papillary projections protruded into the lumina. Mitotic figures were also observed. The lesion was diagnosed as carcinoma of sweat glands. In March, 1957 the patient developed a nodule below the left side of the mandible which measured 2 cm. in diameter. This lesion was excised and showed a picture similar to the original lesion. In January, 1958 the patient developed many masses in the left side of his neck. A radical neck operation was performed. Invasion of lymph nodes was present with cells similar to those seen in the original specimen.

Syringoadenoma Papilliferum

The gross characteristics of syringoadenoma papilliferum are not distinctive. According to Sachs and Lewis[5] the lesions are rose red papules of firm consistency from the size of a pin point to that of a pin head and filled with clear fluid. The areas most commonly involved

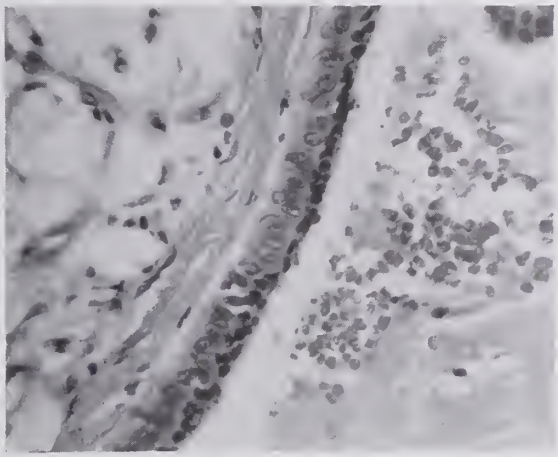


Fig. 5

Case 5. Mixed Tumor. There is a wall composed of two cell types. One cell is small with a dark staining nucleus and the other is columnar with a light staining nucleus. Mucinous and hyaline degeneration are present in the stroma.

are the face, scalp, shoulder, axilla, or genitoinguinal folds. A pore-like opening is often present from which fluid and papillary structures may be expressed.

In Case 1 the patient had a basal cell carcinoma and in Case 3 there was a keratoacanthoma. Gates, Warren, and Warvi[1] reported a case of syringocystadenoma papilliferum surrounded on either side by typical basal cell carcinoma. Syringocystadenoma papilliferum is an apocrine gland adenoma with differentiation toward apocrine ducts. Connections of the apocrine glands with cystic invaginations can be traced. The outer row of cuboidal cells with deep staining nuclei are immature myoepithelial cells and the inner row of high cylindrical cells show evidence of active secretion.

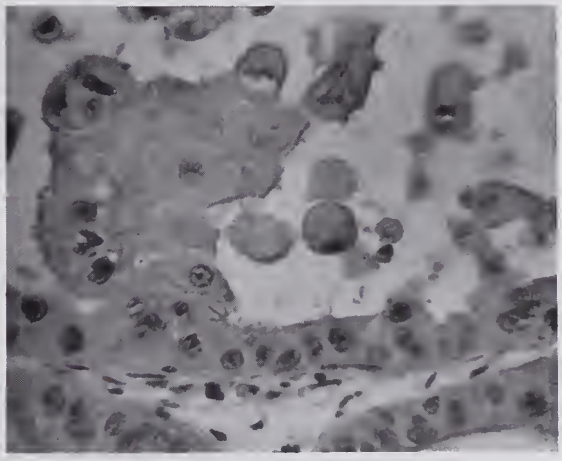


Fig. 6

Case 6. Carcinoma of sweat gland. The wall of the alveolus is lined with squamous cells. Mitotic figures are present. The papillary growth contains keratinized and partially keratinized cells. Lying free in the alveolus are keratinized and partially keratinized epithelial cells.

Myoepithelioma

Lever[3] states that these benign tumors are firm intracutaneous nodules, which measure 0.5 to 2.0 cm. and which are usually encapsulated. There are secretory cells centrally lining the lumen with myoepithelial cells peripherally. The majority of the cells are myoepithelial and fibrils can be noted in the cytoplasm of some of them. These tumors may possess a considerable amount of stroma of hyaline appearance and resemble the mixed tumors. The ectodermal derivation of these growths seems to be universally agreed upon by the anatomists and histologists who have studied the problem.

Mixed Tumors of the Skin

Mixed tumors of the skin have been found in many parts of the body[2] and have been attributed histogenetically to each of the three germ layers. Most writers consider them to be epithelial in nature, the connective tissue and cartilaginous portions the result of activity on the part of the epithelial cells. It is also thought that these tumors are associated with failure of normal development.

Microscopically there are epithelial cells arranged in nests and strands. Sometimes lumina are present in these formations. The stroma is abundant and shows hyaline and mucoid degeneration.

Sweat Gland Carcinoma

Gates, Warren, and Warvi[1] in 1949 found twenty-nine cases of sweat gland carcinoma in the world literature from 1865 through 1939. Only four of these had metastasized and the rest were called carcinoma because of local infiltration and/or cellular anaplasia. Stout[7] in 1951 reported six new cases of metastasizing sweat gland carcinoma and five new cases of comparable tumors showing aggressive growth but without metastases. These tumors chiefly grow in the skin of elderly adults. The favored sites of origin are those in which aprocrine glands normally occur, such as the axillary region, vulva, and scrotum. However, they may arise anywhere in the skin. Metastases occasionally occur in the regional lymph nodes.

Lever[3] presented four cases of carcinoma of sweat glands in which three showed squamous and keratinized cells in addition to glandular cells. On the basis of these findings he proposed that these tumors may represent carcinomas of the epidermal as well as the dermal part of the sweat duct and suggested the term adenoacanthoma. None of Lever's cases metastasized.

Microscopically there are tubular and alveolar lumina lined with one or more layers of epithelium. Where there are many layers the inner cells are squamous and partially keratinized. The lumina are filled with partially or completely keratinized cells. Mitotic figures may be present.

Results

Table 1 shows a comparison of the clinical diagnosis and the pathological diagnosis. In none of these cases were sweat gland tumors suspected.

Table 1

Case	Clinical Diagnosis	Pathological Diagnosis
1	Basal Cell Carcinoma	Syringocystadenoma Papilliferum
2	Melanoma	Syringocystadenoma Papilliferum
3	Squamous Cell Carcinoma	Syringocystadenoma Papilliferum
4	Sebaceous Cyst	Myoepithelioma
5	Squamous Cell Carcinoma	Mixed Tumor of the Skin
6	Squamous Cell Carcinoma	Carcinoma of Sweat Gland

Table 2 shows that in three of the cases there was more than one cutaneous tumor present.

Table 2

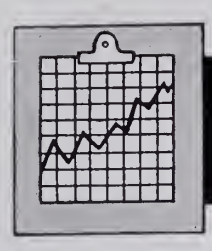
Case	
1	Basal cell carcinoma and syringocystadenoma papilliferum occurred on the same patient but in separate lesions.
3	Keratoacanthoma and syringocystadenoma papilliferum occurred in the same lesion.
6	Squamous cell carcinoma and carcinoma of the sweat glands occurred in separate lesions.

Summary

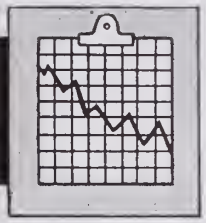
Six cases of tumors of sweat gland origin are presented with a brief discussion. It is thought that sweat gland tumors should be considered more often in the differential diagnosis of nodules and superficial growth of the skin. The occurrence of more than one skin tumor in patients with sweat gland tumors is not uncommon. The relationship of these tumors is unknown.

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CASE DISCUSSIONS
From The
University of Louisville Hospitals



Choriocarcinoma Following Incomplete Abortion

LOUISVILLE GENERAL HOSPITAL

Patient Protocol #168293

History

I. P., a 24-year-old negro gravida 6 para 4, whose youngest child was three and a half years old, was seen on August 6, 1958 with the following history. Her last normal menstrual period had begun on December 6, 1957, and had lasted for five days at that time. On February 16, 1958, the patient noted the onset of cramping lower abdominal pain accompanied by bleeding from the vagina. This continued for several days, until she was seen in the gynecologic outpatient clinic on February 24. At this time, a tentative diagnosis of threatened abortion was made, and it was elected to follow the patient as an ambulatory case. On February 27, 1958, the patient returned to the clinic with a history of having passed tissue suggestive of fetal tissue and clots on the previous day. At this time, there was no vaginal bleeding, and the clinical impression was that the patient had had a complete abortion.

There was no further history of bleeding or other clinical difficulty until April 24, 1958, when there was a recurrent episode of vaginal bleeding, this time described as "flooding." When the patient consulted the physician in the clinic at this time, 50 milligrams of progesterone were administered intravenously; this was done on two separate clinic visits. The patient was next seen on May 22, 1958, in the gynecologic outclinic with a history of heavy vaginal bleeding which had persisted for the past seven days. The bleeding was not considered excessive, and the patient was followed as an out-patient. Following this visit, the bleeding became intermittent, and at the next visit in the gynecologic clinic, on May 27, the bleeding had stopped entirely. The patient then continued without bleeding until June 26, when was again seen; she was at that time experiencing what she said was a normal menstrual period. In July she was seen again, and at this time she gave a history of recurrence in the interim of irregular bleeding for twelve days. At this time it was planned to admit the patient to the hospital for dilatation and curettage.

Physical Findings

At the time of admission, the patient was seen to be a well-developed negro woman in no great distress. She was afebrile. Her blood pressure was 110/70, pulse 80, respirations 16. The general physical examination was within normal limits. On pelvic examination, the external genitalia appeared normal. The cervix was clean, and there was old blood in the vagina. The cervix was dilated approximately one finger tip, and the uterus was described as approximately one and a half times normal size and somewhat softened. The adnexa were not separately palpable. The parametria were normal.

Treatment and Course in the Hospital

On August 8, 1958, the patient was taken to the operating room and dilatation and curettage together with a four-quadrant biopsy of the cervix were undertaken. The uterine cavity was sounded to approximately 13 centimeters. Using dull and sharp curettes, the uterus was scraped and a moderate amount of endometrial tissue and placental tissue was removed. Bleeding was minimal throughout the procedure. The pathologist's report on the fragments removed from the uterus was "chronic cervicitis and choriocarcinoma." The diagnosis of choriocarcinoma was made on the basis of a rather extensively infiltrating trophoblastic tissue deep in the fragments of myometrium.

The patient had been discharged on August 9 before the pathologist's report had been received; as soon as the diagnosis of choriocarcinoma was made, arrangements were made to readmit the patient promptly. This was done on August 16, 1958, and on this admission anteroposterior and lateral films of the chest showed no evidence of metastasis. The physical exam-

ination was as previously described. The hemoglobin was 10.5 grams. A pregnancy test was positive. Urinalysis was within normal limits as were the white count and the differential.

On August 20, 1958, under general anesthesia, the abdomen was opened through vertical midline incision extending from symphysis to umbilicus. The uterus was of normal size and shape, but felt slightly softened in consistency. Both tubes and ovaries appeared entirely normal. The liver and other abdominal organs were within normal limits. A total abdominal hysterectomy and incidental appendectomy were performed without technical difficulty. The pathologist's report on the tissue removed at this operation stated that a tumor mass measuring 1.2 by 1 cm. was seen to project slightly from the surrounding smooth endometrium near the fundus. This mass was ovoid, fairly well demarcated and gray with scattered areas of purplish necrosis. Section through this tumor mass showed it to extend into the myometrium for a distance of nine or ten millimeters. This mass was seen to bulge on section and appeared gray and well demarcated from the surrounding myometrial tissue. The microscopic interpretation of the tissue from the tumor mass described with choriocarcinoma of the uterus. The remaining tissue was not unusual. The patient's postoperative course was uncomplicated; on August 16 and August 25, 1958, pregnancy tests were performed and were reported as positive, but on September 19, a repeat test was reported as negative.

The patient was last seen on October 16, 1958, at which time a recheck of the chest showed no change in the roentgenologic appearance of the heart or lungs, and no evidence of metastasis or other abnormality. The pelvic examination was entirely normal. The patient had no complaints and seemed to be in excellent condition.

Discussion

Douglas M. Haynes, M.D.; Professor and Chairman, Department of Obstetrics and Gynecology; The unusual diagnosis of choriocarcinoma arising in the uterus is one that has attracted much attention and discussion in the gynecologic and obstetric literature. Choriocarcinoma is one of the most malignant tumors which can arise in the female genital tract; it is, of course, not limited to that tract, as it may also be found as a teratomatous metamorphosis in the testicle. This must be considered to be a tumor of embryonic rather than of uterine origin, and most authorities consider it to be a frank carcinoma arising in the chorionic epithelium. The histologic diagnosis of choriocarcinoma is rarely made as it was in the present case, as it is not unusual for extremely malignant-looking invasive trophoblastic tissue to be seen infiltrating the wall of the myometrium in a normal pregnancy. It must be remembered that the normal trophoblast possesses qualities of invasiveness which may be difficult or impossible to distinguish from an invasive malignant tumor. The difference between choriocarcinoma and normally invasive trophoblast lies in the greatly exaggerated tendency of the carcinoma to invade blood vessels and produce actual erosion of these with distant metastases. The characteristic gross picture is compatible with that which was reported in the present case, namely that of a very rapidly growing mass which invades the uterine muscle and produces areas of hemorrhage which appear as purplish areas on the cut section. Bleeding and sloughing of the surface will occur when the mass impinges on the endometrial cavity, and it is probable that some of the patient's persistent irregular bleeding prior to the dilatation and curettage might have been produced by the tumor itself.

The diagnostic point which suggested choriocarcinoma to the pathologist in the present instance was the complete absence of a villous pattern, as the anaplasia of the cells is a notably fallacious criterion when dealing with trophoblastic tissue of any sort. The great difficulty of evaluating the cytology of these tumors is the principal factor which causes the diagnosis of choriocarcinoma to be problematic when made from curettings alone. Metastasis tends to occur quite early, and because of the trophoblastic tendency to invade blood vessels tends to be hematogenous in its spread. The commonest site for metastasis is the lungs, and the second most common the vagina; when vaginal metastases are present, they constitute a very characteristic gross finding, with marked hemorrhagic extravasation below the vaginal mucosa, and great accumulations of blood bordered in biopsy sections by invading malignant trophoblastic tissue.

The clinical picture of choriocarcinoma is one which is extremely difficult to characterize. Since the lesion occurs only once in many thousands of pregnancy episodes, its incidence

is extremely difficult to determine. However, choriocarcinoma may be said to arise following a pregnancy episode except for those few cases in which the choriocarcinomatous transformation occurs in a pre-existing teratoma. Approximately one half of all choriocarcinomas follow a hydatidiform mole; approximately twenty-five per cent will follow a normal pregnancy, and the remaining twenty-five per cent will follow an incomplete abortion, as was the case in the present patient. Since the incidence of hydatidiform mole is quite low, and yet one half of all choriocarcinoma arises following this lesion, it is feasible and indicated to follow patients with pregnancy tests at frequent intervals after evacuation of a mole. If the test becomes negative and then at a subsequent examination it is again positive, immediate hysterectomy might conceivably cure the patient if she has a choriocarcinoma confined to the uterus. Obviously, the cooperation of the patient in the matter of avoidance of pregnancy during this time must be secured and relied upon. Even if the excised uterus shows persistent trophoblastic invasion, the definitive diagnosis of choriocarcinoma is likely to remain in question unless distant metastases supervene, so that proof of cure is virtually unobtainable in these patients; nevertheless, it seems in the patient's best interest to proceed in the matter outlined in the absence of more precise diagnostic criteria.

When, as in the present case, the diagnosis of choriocarcinoma has been made with reasonable assurance of its accuracy, hysterectomy should be done, and any localized metastatic foci in the pelvis, vulva or vagina should be excised at the same time if this is surgically feasible. Some writers have reported regression of the metastases following removal of the primary tumor, although it may be questioned whether or not any patient has ever been permanently cured by such management.

Ninth Annual

County Society Officers Conference

- **OUTSTANDING SPEAKERS**
- **SUBJECTS OF VITAL INTEREST**
- **PANEL DISCUSSION**

March 26

Phoenix Hotel—Lexington



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Tetracycline with Citric Acid *LEDERLE*

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EDITORIALS

Concerning Medical Research

THERE came to our desk recently a letter from Mr. George F. Smith, President of Pharmaceutical Manufacturers Association, attempting to set forth the position of this group with reference to their part in Medical Research. In his letter he stated that the Pharmaceutical Industries spent $170,000,000.00 for Medical Research in 1958 and contemplates research expenditures of $190,000,000.00 in 1959. He stated that the aim of this Industry is to link its efforts intimately to the more basic research and training carried on by the nation's academic institutions.

Toward this end the Pharmaceutical Manufacturers Association, by the action of its Board of Directors, issued a "Statement on Governmental Support of Medical Research." This report states that some noteworthy basic research is being carried out in the laboratories of the pharmaceutical industries, but the major centers of this basic effort are non-profit centers; universities, medical schools, and research institutions. The most epoch-making scientific discoveries have come from basic research, which has primarily been carried on by these agencies. It is our basic knowledge that needs to be increased as rapidly as possible and federal funds should be channeled to academic institutions, which need them to support and expand their research.

With total medical research activities, the paramount problem is the critical shortage of scientific personnel. There is at present a marked deficit among scientists trained for basic research. This is indicated by the alarming number of unfilled faculty positions in our medical schools today.

The board enunciated the following principles, which it recommended for adoption.

1. Since our further progress in medicine directly depends upon the supply of highly-qualified scientists, the training of additional teachers and research personnel should have highest priority.

2. Government funds should be principally allocated to basic research objectives, to expand our fundamental knowledge in all medical fields, rather than to applied research and development.

3. Except in unusual circumstances, government funds should therefore be allocated to non-profit institutions, such as medical schools, hospitals, and research institutions, rather than to private industry. Private industry should be subsidized only in cases where no non-profit organization can do the job.

This is the expression of a cooperative, unselfish attitude on the part of the Pharmaceutical Manufacturers Association. We wish to express officially our commendation of their action. Their contributions to medical progress, already great, should be tremendously enhanced by the adoption of the principles which they advocate.

Sam A. Overstreet, M.D.

Iatrogenic Disease

THE word Iatrogenic is derived from a Greek word meaning Physician. Iatrogenic disease, therefore, refers to a disease state induced by the physician in using diagnostic or therapeutic measures. In recent years with the development of potent new drugs, expanding surgical procedures and more emphasis on investigative studies Iatrogenic disease has become of unprecedented importance. No one can deny that the patient has obtained inestimable benefits from these new advances in medicine but we must be ever aware that the hazards of modern medical management have enormously increased at the same time.

Before any drug is given or any therapeutic

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

or diagnostic procedure is ordered it is the responsibility of the physician to know what undesirable side effects may be expected and to make frequent checks so that these side effects, if they occur, may be recognized early. Prolonged use of any drug should be avoided, if possible, and great care should be exercised to avoid overdosage. Try to prevent a disease that would not have occurred if some drug or procedure had not been ordered.

Iatrogenic disease, especially Iatrogenic heart disease may be directly related to words or actions of the physician.

Oxygen is frequently life saving in premature infants but Pediatricians and Ophthalmologists now recognize that Retrolental Fibroplasia may occur if prolonged oxygen is used. In prolonged oxygen usage in the adult patient with advanced pulmonary emphysema carbon dioxide narcosis and coma may occur.

Hypersensitivity reactions may occur from sulfonamides and serums, with the end result of periarteritis nodosa. Apresoline may present a Lupus Erythematosis type of hypersensitivity reaction and interstitial fibrosis has been reported with the use of hexamethonium.

In the management of hypertension the ganglion blocking agents may produce marked postural hypotension. Mental depressions, Parkinsonianism, and even Epileptiform seizures have been reported with the use of the Rauwolfia preparations. Diuril may cause hypopotassemia or other electrolyte disturbances.

The use of steroids in large amounts or over a long period of time may result in acute psychic disturbances, ulceration of the gastrointestinal tract, reactivation of an old tuberculosis lesion, osteoporosis with compression fractures of the spine, or they may mask an infectious process. Adrenal suppression may occur after steroids are discontinued and be a threat to surgery, anesthesia, or trauma for several months.

Hepatitis with intra hepatic obstruction may occur with thorazine or methyltestosterone. Toxic hepatitis may occur with gold therapy, sulfonamides, butazoludine and other drugs.

Progress in the development of antibiotics has created new problems such as allergic or anaphylactic reactions to penicillin and monilia infection of the mouth or gastrointestinal tract with the use of broad spectrum antibiotics. The drug resistant staphyloccus is also becoming more of a problem. Acute staphlococcus enterocolitis may result in death if not recognized and treated promptly.

Bleeding from the use of anticoagulants, urinary retention from the use of banthine, gynecomastia from digitalis and the various hematologic complications of so many drugs are only a few more of the many types of Iatrogenic disease that we might mention.

In medicine as in other professions there is no gain without a relative loss. Progress always creates new problems. Hazards must be accepted as the price we physicians must pay for progress in medicine. The important thing is to recognize our responsibility and to use sound, conscientious, thoughtful judgment when we prescribe for our patients. Weigh the merits of the proposed drug against the possible hazards.

George W. Pedigo, Jr., M.D.

New Record Encourages

KSMA members set a new record for the payment of annual dues to the county, state, and AMA groups for the month of January, 1959. Your County Society Secretary says a most heartfelt "thank you" to those who cooperated.

As of February 1, the membership department of KSMA had received annual dues from 25 per cent of all Kentucky physicians—this was seven percentage points higher than 1958 and 15 per cent higher than in 1957. This new high comes in spite of an increase in the 1959 KSMA dues.

Your fine performance would seem to indicate the recognition of two eminent facts:

1. The increasingly important part that organized medicine is destined to play in our professional life and your desire to support the organization.

2. Your willingness to be considerate of your fellow colleague—your County Medical Society Secretary—by paying your dues early.

To you who have not paid your local, state, and AMA dues, may we say this—Remember he is your County Society Secretary and like you has many demands on his time. He will be grateful to your thoughtfulness in sending in your dues *now*. He, like you, should be free to treat the ill to the best of his ability. Let's not make bill collectors out of our county society secretaries.

SPECIAL ARTICLES

Drought on the Grass Roots*

E. L. BERNHART**
Milwaukee, Wis.

SEVERAL months ago an important public spokesman in Wisconsin stated:

"The physician has more to lose before the legislature and the Congress than any other person in our society. Yet he contributes less in time and effort than any other in the support of candidates for public offices."

This is a shocking statement. Can it be true?

This spokesman has been active in political circles for many years. His experience has come from the state and the national scene. He declared that his remarks were not limited to Wisconsin alone, but could be generally applied across the nation.

Your Wants

Let me continue for a moment with what this man said:

He said, you physicians want to keep the chiropractor within his limits. You want the Congress to go slow on social security expansion. You oppose compulsory social security coverage for physicians. You want free choice of physician under Medicare. You oppose government intervention in medical education. You oppose bureaucratic governmental medicine in any form. These are all sound proposals.

But the trouble with physicians, this man said, is that they do not seem to realize that while they are meeting to pass resolutions, the chiropractors, the quacks and the socializers are electing a legislature or a congress. It is the legislature which enacts the laws, and to this date, no county, state or American Medical Society resolution has had the same effect.

By and large, he said, the legislation is in the hopper and well on the way to passage when the physician wakes up. But he wakes up too late.

Let me illustrate again by an example from my own state. I choose a local example not because it is peculiar to my state, but because someone here might be so naive as to believe that it could not occur in his community. I would not want to offend him.

Chiropractic Requests

Two years ago, about six months before the 1957 Wisconsin legislature convened, chiropractic groups frequently accompanied by local businessmen and labor leaders put their requests to legislative candidates. Superficially it sounded reasonable to some one not familiar with the chiropractic threat. Their request went like this:

. . . The Wisconsin legislature, in its good judgment, licensed chiropractic in 1925. This, of course, was in recognition of its effectiveness in the treatment of the sick.

. . . Since then chiropractic educational requirements have been substantially increased. The applicant for chiropractic license must take the basic science examination. This assures the public of his competence.

. . . Despite this, the chiropractor and, more important, the patient who demands his service is discriminated against. He is denied the benefits of the workmen's compensation and public assistance programs. The only reason for this is the opposition of the "medical trust."

. . . All we as chiropractors ask is the opportunity to serve our patients, and the legislation we propose will permit nothing more.

Commitments Made

The legislator receiving this information in the presence of a group of friends and neighbors—and voters—and without the benefit of all the facts was likely to make decisions, if not commitments. By the time the legislative session rolled around many of these same legislators, when given the facts, would have liked to have changed their position. But they couldn't change because of commitments already made to constituents.

You may feel that the legislator had the responsibility to seek out the physician, or at least to take no position until the whole story was told. Perhaps this is so, but you know that in the world of practical politics it doesn't work that way.

What's Wrong?

What's wrong in the legislative arena? Why is it, as one capital columnist puts it, that medics are so frequently caught with their stethoscopes plugged? Why is it that medicine so frequently has to resort to crash programs of last-minute legislative pressure to delay or defeat anti-health measures or obtain support for its own public health proposals?

Last January the Journal of the History of Medicine and Allied Sciences carried a most interesting report on the genesis and impact of the medical lobby since 1898. This paper traced the factors leading to the organization of the AMA Committee on National Legislation. The Committee was established in 1898 not only as a negative force to oppose antivivesection bills and higher postal rates for medical

*Presented at a meeting of the Fifth Councilor District of the KSMA (Jefferson County Medical Society) at the Medical Arts Building in Louisville on November 17, 1959.

**President of Conference of Presidents and Other Officers of State Medical Associations.

journals, but to support national sanitary laws, better medical care for the armed forces and higher standards of medical education.

Better Medical Care

By 1906 the AMA had successfully battled with President Theodore Roosevelt and his administration to provide better medical care to workers constructing the Panama Canal; it had triumphed over the powerful distillers trust and the right wing of the Republican party in order to pass the Pure Food and Drug Act of 1906. And now to quote a very important sentence: "In a seven year period a politically powerless profession was organized into one of the most politically potent grass roots lobbies in the United States."

In the years since that time few lobbies have been the subject of more controversy than that of the medical profession. Its determination and political skill have won the respect of both its friends and foes. And, I dare say that no lobby has ever been more consistently dedicated to public service through the improvement of public health.

Despite all this, medicine appears suddenly to be faced from every quarter with charges that the physician is doing little to support candidates for public office and that his dilemma in the legislative hall is of his own making.

The Drought

What kind of drought has spread over the grass roots of American medicine? What kind of reclamation projects are needed to restore vigor to these dead and dying grass roots? Is there anything more important in the interests of preserving and improving the quality of medical care?

Perhaps the writings of one experienced newspaper reporter tell the story. Commenting on the triumph of a chiropractic bill over the opposition of the local medical society the reporter said:

"The chiropractic lobby was almost a clinical example of the pressure group in action in the legislature. Literally scores of chiropractors left their offices and clinics to participate.

"The doctors for their part did little of such pressuring. They have a competent and experienced counsel who presented the issues as the doctors saw them. The fact that he found himself on the losing side of the roll call does not reflect upon his professional or political skill any more than it suggests the merit of the question. What it does suggest is that the doctors must fight fire with fire.

"To the conscientious physician working in his home town and engaged heavily in watching over the interests of his patients, it may appear strange that he should also be obliged to participate in the business of politics by communicating with his legislative representatives and explaining the merits of pending bills as they strike him. Yet the practical world of politics is a cruel one and it demands exactly such activity from the physicians as it demands from the lawyers, dry cleaners, farmers and merchants when issues striking at their fundamental concerns arise in the legislative arena."

Now there must be a reason why the medical profession finds itself confronted with these situations so frequently.

And there is a reason.

Unaware of Danger

We, the presidents and officers of our state medical societies, have simply not laid the facts on the line to our members. Our members are not really aware of their danger.

We ourselves have become too complacent with the illusion that somebody will do something when the time comes—that resolutions rightly timed will turn the tide—that the legislature or the congress can be persuaded by honest and skillful lobbying—that a well documented, strong appeal before the committee hearing will cause the law-making body to do what it should.

Nothing could be further from the truth.

Personal Contact

Medicine is failing to protect itself and failing to protect public health by forgetting the first fundamental of grass roots politics—personal contact. True, we have done a great deal of grass roots *talking* at medical meetings as far back as I can remember. But for some reason, our talk seems to have been nothing but hot air. Without some grass roots *action* all of our talking is worthless.

I think the medical profession and physicians must stop looking for excuses to stay out of politics. I would not say to you that you should enter the ring with chiropractic in the opposite corner. I would by no means suggest that the practicing physician spend his working days from Tuesday through Thursday in the legislature. I would not think of inviting an entire county medical society to swarm over the legislative halls. Physicians are taking care of sick people. The many demands made upon them for individual and community health must and should come first. It is not necessary and should never be necessary for physicians to become residents in the halls of Congress or the state legislatures.

Medicine's Duty

I *am* saying that it is the duty of medicine, and by that I mean every individual physician, to provide information, to provide facts, and to do it honestly and fairly, to every public official—municipal, county, state, and national. And don't forget that policies begin in the city council and the county board. Many of the men who move into state and national legislative positions get their start in local offices. That is where they form their first impressions of the physicians.

The profession is constantly fending off the quack and the cultist. It is constantly under severe attack for the increased costs of "medical care."

Invariably the legislator's knowledge of the difference between cultism and professional health care is meager or even non-existent. Few of the critics of the costs of medical care have made any effort to distinguish the costs of hospitalization and ancillary services from the costs of physicians' services.

The Truth

Medical men know the truth about these problems. However, the facts are without value unless they reach the legislator.

Our failure to convey them carries the probability of severe penalty. That penalty, of course, is punitive

or thoughtless legislation resulting from ignorance of those facts.

I think physicians should stop being afraid to speak out in public. Official government statistics tell us that there are some 5,000 chambers of commerce and some 10,000 luncheon and service clubs in America. There are thousands of voluntary and public groups of various types.

One would assume that the average physician must belong to many of these different organizations. If so, it would seem that the physician would be highly informed on many facts of our political life and some of the special needs in the public health field. It would seem that by his very presence in these groups he should occasionally be so frightened or angry—or even so patriotic—to have long since roused himself in protection of his profession and his family and the public health from some of the threats that make their appearance there.

Physician Participation

What's wrong? Why hasn't he? Perhaps the answer can be found in a survey that one state medical association conducted among its members as to their participation in public and civic affairs. Among other things the survey revealed that only 26 out of every 100 physicians belong to a chamber of commerce. Only 33 out of every 100 physicians was a member of Kiwanis, Optimists, Elks, Rotary, or Lions. And only 15 out of every 100 physicians was serving on a board of health, board of education, as coroner, on the county board, county health committee, county public welfare committee, a city council or village board or as mayor or alderman. Do these sound like the statistics of community leadership for which the medical profession has so great a reputation?

I think our legal counsel at the national and state levels must turn the emphasis from what we can't do in politics to what we can do if we want to. Labor is subject to exactly the same restrictions against political action as medical organization, yet look what it has done in building an influential legislation program within the last ten years. Business is another segment of society in which political action is subject to the same restrictions as would apply to the medical organization. Yet look at its activity and influence; not only on behalf of its own interests, but in the interests of the people as a whole.

Fundamental Concept

I would say to you that medicine and the care of the sick and public health are not Republican issues. They are not Democratic issues. The fundamental concept of medicine is to increase its capacity to serve the sick and to protect the healthy. One of its major obligations is to protect the sick from false hope, unnecessary expense, and waste of time. There are champions of these principles among both Republicans and Democrats.

But yours, doctor, is the responsibility to assure that your legislator is strong and intelligent in his conviction. The physician must know his legislative candidates. He must furnish them with information. And he must assist the worthy candidate of whatever party in his effort to achieve public office.

There is one more thing I would have you do. Right now in each congressional district a half dozen political leaders in each party are deciding who shall run for Congress. The same thing is going on in every legislative district in every state in this Union. An equal number of leading physicians, if they really cared and if they really represented the medical profession, could exert a strong influence on this selection and on who gets elected. I would wager that few physicians know or even care about who is running for the next legislature or the next congress. As a result, candidates committed to quack and cultist philosophies and to grandiose socialistic schemes are being designated for nomination. They will be elected to office to get special favors for the special groups who organize to put them there. Oddly enough, these groups are small minority groups, often smaller than medicine itself.

Last Ditch Effort

Then after the election, medicine, through its thousands of local societies will be called upon to make a last ditch effort to present the validity of its program to legislators already pledged to vote against it. Does this make sense?

Let me illustrate the problem.

Recently a state gubernatorial candidate embarked on a 1,600 mile campaign swing involving 15 to 20 meetings. At every meeting there were one or more chiropractors present. This candidate reported the chiropractors made it a point to introduce themselves, express their interest in his candidacy, their desire to render assistance and make a few brief statements about their viewpoint on health matters. At not a single meeting was there a physician present. This legislator suggested that the least the physicians could do would be to invite the legislative candidates of both parties to county medical society meetings.

Let me give you another example:

A congressional candidate of my acquaintance is a man of modest means and out of necessity has to turn to interested citizens of his district for assistance. A physician in this district was prevailed upon to undertake efforts among the profession to assist the campaign in a financial way. The physician, after two weeks of intensive campaigning among his fellow practitioners was forced to report that he had collected not a single dollar.

The Response

Gentlemen, this was the response of the medical profession to a man whose support for public health and medicine has never wavered!

How long can medicine expect to keep its legislative friends in any party if it does not accept the responsibility of citizens for participation in the most basic of democratic processes—the selection and support of competent, well qualified and well informed legislative candidates.

If the medical men of America, with their myriads of contacts through organizations of every type will not see to it that men are elected, committed to fight quackery and cultism, committed to improving public health, committed to oppose compulsory medical schemes, who else will?

The Sprinkling System

No one! The medical leadership—that means you

(Continued on page 333)

ORGANIZATION SECTION

Third Party Medicine on Agenda of Co. Soc. Conference

"Various facets of one of the most challenging issues facing the medical profession—third party medicine—will be discussed by experienced authorities at your ninth annual County Society Officers Conference at the Phoenix Hotel, Lexington, March 26," said Robert W. Robertson, M.D., KSMA president.

"Leaders in medicine—on both the state and county levels—should be most interested in how 'experts' from various parts of the nation think the challenge can be met," Doctor Robertson said.

A panel covering different aspects of the problem will be featured on the morning program. Hugh Brenneman, public relations counsel for the Michigan State Medical Society, will moderate the panel. "Legislating Health Care for Our Senior Citizens" will be discussed by Ernest B. Howard, M.D., Chicago, assistant executive vice president of the AMA. Leslie Hodson, legal counsel for the AMA, will talk on "Laws Applicable to Medical Society Relations with Closed Panel Plans." Winding up the panel will be a talk by Donald Cass, M.D., on "Do Medical Societies Need Physician Policing?".

Russell B. Roth, M.D., Erie, chairman of the Board of Trustees of the Medical Society of the State of Pennsylvania, will give the luncheon address. His illustrated lecture will be "What's Funny About Practicing Medicine?".

"Blue Shield and American Medicine" will be the topic of Donald Stubbs, M.D., Washington, D. C., chairman, Board of Directors, Blue Shield Medical Care Plans, who will be the closing speaker.

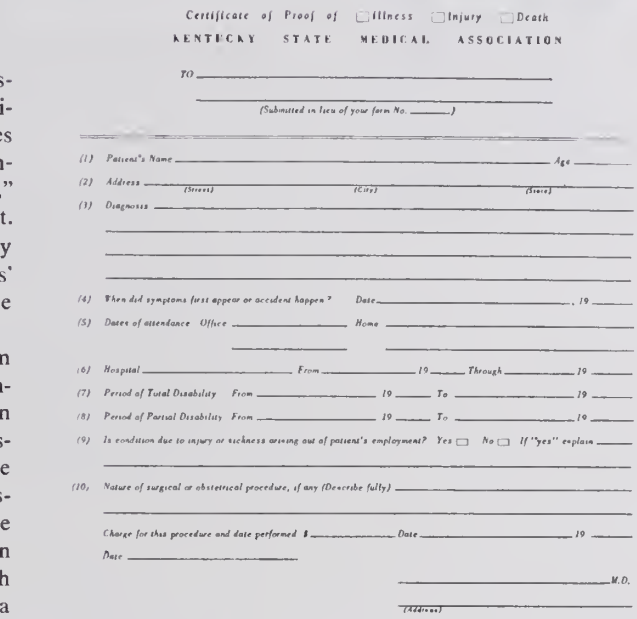
Biographical information on Leslie Hodson, which did not arrive in time for inclusion in the February issue follows:

A member of a Chicago law firm, Mr. Hodson graduated from Harvard Law School in 1929 with an LL. B. degree. He is a member of the Chicago, Illinois State, and American Bar Associations; the Seldon Society, and American College of Trial Lawyers. He serves as antitrust lawyer for the AMA and frequently tries cases before the U. S. Supreme Court.

New Insurance Claim Forms Now Available to M.D.'s

The KSMA Insurance Committee has developed a new short insurance claim form (pictured above) for use in reporting proof of claim on accident and health cases to insurance companies.

The product of months of study by the KSMA Insurance Committee, Council, and House of Delegates with the collaboration of the Kentucky Committee of the Health Insurance Council and the



Certificate of Proof of ☐ Illness ☐ Injury ☐ Death

KENTUCKY STATE MEDICAL ASSOCIATION

TO _____

_____

(Submitted in lieu of your form No. _____)

(1) Patient's Name _____ Age _____

(2) Address _____ (Street) (City) (State)

(3) Diagnosis _____

(4) When did symptoms first appear or accident happen? Date _____, 19 ____

(5) Dates of attendance Office _____ Home _____

(6) Hospital _____ From _____ 19 ____ Through _____ 19 ____

(7) Period of Total Disability From _____ 19 ____ To _____ 19 ____

(8) Period of Partial Disability From _____ 19 ____ To _____ 19 ____

(9) Is condition due to injury or sickness arising out of patient's employment? Yes ☐ No ☐ If "yes" explain _____

(10) Nature of surgical or obstetrical procedure, if any (Describe fully) _____

Charge for this procedure and date performed $ _____ Date _____ 19 ____

Date _____

_____ M.D.

(Address) _____

RELEASE TO BE SIGNED BY PATIENT IS PRINTED ON REVERSE SIDE

FOR REMARKS AND CONTINUED ITEMS, SEE REVERSE SIDE

Kentucky Insurance Commissioner's office, the simplified form is similar to standard short forms used in many other states.

Although there is no guarantee that all insurance companies will accept the new KSMA approved form, it is anticipated that it will eventually be accepted by all insurance companies in lieu of their own forms. It should *not,* however, be substituted for a claim form of any government agency, nor should it be used in place of the claim form used by Kentucky Physicians Mutual (Blue Shield Plan for Kentucky) which requires less information, than the KSMA approved form.

The new form is printed in duplicate sets of 60 each. The original form, which is printed in white, should be completed and attached to the insurance company's form and returned to the company. The colored form is the duplicate to be kept in your files.

Members wishing to order these forms, which cost $1.00 per pad of 60 forms, should order directly from the printer, Mr. Walter J. Hennig, 1213 South 6th St., Louisville, Ky. Checks or money orders should accompany each order.

Of "Timely" Importance

All sessions of the County Society Officers Conference on March 26 will be conducted on Central Daylight Saving Time, since Lexington is on that time. Members coming from parts of the state on Central Standard Time, are urged to plan accordingly. The meeting will start at 9:40 a. m. (CDST).

Dr. Carl S. Winters to Speak at Annual Senior Day

One of America's foremost inspirational speakers and humorists, Dr. Carl S. Winters, pastor of the First Baptist Church, Oak Park, Ill., will be featured speaker at the annual Senior Day in Louisville on March 16.


Dr. Winters

Announcement of the day, which is aimed at making the transition from student to M.D. easier for June graduates of the U of L School of Medicine, was made by Nathaniel L. Bosworth, M.D., Lexington, chairman of the KSMA Senior Day Committee.

Doctor Winters, former Crime Commissioner of Michigan and chairman of the Skid Row Commission of Chicago, not only has an American audience of more than a quarter-million people a year, but also has made world-wide tours speaking to business and educational groups in Rome, Paris, London, Cairo, Tokyo, Hong Kong, and New Delhi. He is appearing through the cooperation of General Motors Corporation.

Fifteen Kentucky physicians, including R. W. Robertson, M.D., Paducah, KSMA president, will address the seniors. Doctor Robertson's topic "End of the Beginning" will open the Day at the Rankin Amphitheater. Afternoon session will be held in Parlors B and C at the Kentucky Hotel and the dinner and social hour will start at 6:30 in the Mirror Room of the Kentucky.

The Jefferson County Medical Society will be host at the dinner with Foster D. Coleman, M.D., president, Jefferson County Medical Society, presiding. Senior Day is traditionally sponsored by the KSMA with the cooperation of the Jefferson County Medical Society and the U of L School of Medicine.

Councilor Districts 6, 13, 14 Plan April Meetings

Three KSMA Councilor Districts are planning meetings during April, according to announcements from John P. Glenn, M.D., Russellville; Charles B. Johnson, Russell; and Charles C. Rutledge. Hazard, Councilors for the respective districts.

First meeting scheduled is that of the Fourteenth Councilor District at the Pikeville Country Club on April 8. According to Doctor Rutledge a late afternoon and evening session are being planned.

On April 8 the Thirteenth Councilor District is holding a joint meeting with District Four State TB Hospital, and the KAGP. It will be held in Ashland and is scheduled to begin at 7 p.m. (EST).

The third Councilor district meeting of the month will be a joint meeting of the Sixth Councilor District, District Six State TB Hospital, and the KAGP at Glasgow at 6 p.m. (CST), on April 21.

All of these meetings are part of the KSMA's continuing program to provide postgraduate medical education for physicians on a local level.

Chairman Announces Full Program of Annual KAGP Meet

Eleven top notch speakers from throughout the nation will participate in the Eighth Annual Scientific Assembly of the Kentucky Academy of General Practice at the Kentucky Hotel in Louisville on April 22, 23, and 24, it has been announced by Stuart M. Hunter, M.D., Louisville, chairman.

"What a Wonderful World to Live In" will be the topic of a talk by Joseph G. Molner, M.D., M.P.H., Detroit's Commissioner of Health and well known columnist, at the annual banquet on Thursday evening, April 23.

Following is the Assembly program:

Wednesday Morning—April 22

"Miscarriage Prone Pregnancies," Charles H. Birnberg, M.D., Brooklyn, N. Y.

"Office Orthopedics," Harry B. Hall, M.D., Minneapolis, Minn.

"Surgery in Cardiacs," Arthur C. Kerkof, M.D., Minneapolis, Minn.

"Recent Advances in Oral Hypoglycemic Agents in the Treatment of Diabetes Mellitis," George J. Hamwi, M.D., Columbus, Ohio

Wednesday Afternoon—April 22

"Recent Advances in Diagnosis and Treatment of Thyroid Disorders," George J. Hamwi, M.D., Columbus, Ohio

"Effective Drugs in the Treatment of Heart Disease," Arthur C. Kerkhof, M.D., Minneapolis, Minn.

"The Glucose Oxidase Test," Charles H. Birnberg, M.D., Brooklyn, N. Y.

"Diagnosis and Treatment of Shoulder Pain," Harry B. Hall, M.D., Minneapolis, Minn.

Thursday Morning—April 23

"Recent Developments in the Treatment of Intestinal Infections," William W. Frye, M.D., New Orleans, La.

"Diarrhea in Infants as Considered and Treated Outside the Hospital," Harry C. Shirkey, M.D., Cincinnati, Ohio

"Aortic Insufficiency," Charles A. Hufnagel, M.D., Washington, D. C.

"Immunization Procedures in the General Practice of Pediatrics," R. Cannon Eley, M.D., Boston, Mass.

Thursday Afternoon—April 23

"Myocardial Revascularization," Charles A. Hufnagel, M.D., Washington, D. C.

"Studies on the Diagnosis and Treatment of Colitis," William W. Frye, M.D., New Orleans, La.

"Drug Therapy in Children," Harry C. Shirkey, M.D., Cincinnati, Ohio

"The Role of Steroids in Contagious Diseases," R. Cannon Eley, M.D., Boston, Mass.

Thursday Evening—April 23

"What a Wonderful World to Live In," Joseph G. Molner, M.D., M.P.H., Detroit, Mich.



IN DEBILITATING DISEASE

Patients receiving

NILEVAR®

Eat more...
Feel better...
Recover faster

Compared to control patients, those receiving Nilevar (brand of norethandrolone) have repeatedly demonstrated more rapid and more complete recovery from serious acute illness and increased comfort and well-being in chronic illness.

A multitude of case histories are now adding individual clinical color to the earlier controlled investigations which defined the actions of Nilevar as an effective aid in reversing negative nitrogen balance and in building protein tissue.

In typical case reports such gratifying comments as these appear:

Underweight —"Appetite considerably increased within one week. Sense of well-being and vigor increased along with increased appetite."

Prematurity (Birth weight: 2 pounds, 4 ounces) — "Gradual improvement in appetite and capacity for formula. . . . Excellent progress and weight gain for a very immature infant."

Carcinoma of the Uterus —"Within four days appetite became excellent, took full diet. . . . More ambition while on Nilevar. Enjoys life. Takes part in church and other social affairs."

Third Degree Burn—". . . soon began eating all that was offered. . . . Began to show signs of hope for recovery. . . . Perhaps one of the greatest changes was in the appearance of his wounds which were so very much improved."

The dosage for adults is 20 to 30 mg. daily in single courses no longer than three months. For children the daily dosage is 0.5 mg. per kilogram of body weight, in single courses no longer than three months.

Nilevar is supplied in tablets of 10 mg., ampuls of 25 mg. (1 cc.) and Nilevar Drops of 0.25 mg. per drop.

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BONADOXIN®

(tablets and drops)

STOPS STOPS STOPS MORNING SICKNESS



BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride .. 8.33 mg.
Pyridoxine hydrochloride ...16.67 mg.

Dosage:

under 6 months . . . . 0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. **40**:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. **2**:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. **6**:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. **8**:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. **3**:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. **57**:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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Science for the World's Well-Being

Friday Morning—April 24

"Alcoholism," Donald W. Brodie, M.D., Indianapolis, Ind.

"Chemotherapy of Human Solid Tumors," Robert G. Ravdin, M.D., Philadelphia, Pa.

"Treatment of the Alcoholic," Donald W. Brodie, M.D., Indianapolis, Ind.

"Carcinoma of the Breast," Robert G. Ravdin, M.D., Philadelphia, Pa.

Contest Deadline is March 15

Deadline on sending the winning county papers in the Essay Contest sponsored by the Association of American Physicians and Surgeons, Inc., in to the Headquarters Office at 1169 Eastern Parkway, Louisville 17, is March 15. Entries sent in from the county societies will be judged by the KSMA Committee on Public Information and Service and the state winner will receive a $100 prize from the KSMA. The winning state essay will be sent to the national office of the AAPS to compete for the first prize of $1000.

Committee Announces PG Opportunities in Kentucky for Second Quarter

At the direction of the KSMA Committee on Postgraduate Medical Education the Journal is printing a list of postgraduate medical opportunities available in the state for the next three months.

The Committee, which is headed by Walter Coe, M.D., Louisville, is making these quarterly listings available so that physicians in the state may be kept up-to-date on the opportunities for PG medical training available in forthcoming months. It decided to list the opportunities for each quarter, rather than giving one yearly listing, to promote attendance at these valuable sessions.

Specialty groups are encouraged to send programs of their meetings to the Headquarters Office so that they may be publicized in the Organization Section of the Journal.

Following is a listing of postgraduate opportunities in Kentucky for April, May, and June received at press time.

April

1-2 Southeastern Section of the American Urological Association, Brown Hotel, Louisville (begins March 29)

1-2 Annual Meeting Kentucky Public Health Association, Sheraton Hotel, Louisville (begins March 31), 9:30 a.m.

8 Fourteenth Councilor District meeting, Pikeville Country Club, (late afternoon and evening program)

9 Joint meeting of Thirteenth Councilor District of KSMA, District Four State TB Hospital, and the KAGP, Ashland, 7 p.m. (EST)

11 Kentucky Society of Pathologists, Covington area (site undetermined at press time) 3 p.m. followed by dinner, KSMA members invited as paying guests—make reservations

14 Pediatric Postgraduate Course—every Tuesday through June 2—Children's Hospital, Louisville, 9:30 a.m. to 12:30 p.m.

21 Joint meeting of the Sixth Councilor District of the KSMA, District Six State TB Hospital, and the KAGP, Glasgow, 6 p.m.

22 Kentucky Psychiatric Association—Spring Meeting—Phoenix Hotel, Lexington, 6:30 p.m.

22-23-24 Kentucky Academy of General Practice—Annual Scientific Assembly — Kentucky Hotel, Louisville

May

5 Pediatric Postgraduate Course—every Tuesday through June 2—Children's Hospital, Louisville 9:30 a.m. to 12:30 p.m.

7-9 Kentucky Obstetrical and Gynecologic Society—Annual Meeting—Kentucky Dam Village State Park

14 Kentucky Chapter, American Academy of Pediatrics, Children's Hospital, Louisville, 3 p.m., followed by social hour and dinner 6:30 Medical Arts Building

15-16 Kentucky Chapter, American College of Surgeons, Kentucky Surgical Society, and the Indiana Chapter, American College of Surgeons—joint meeting — French Lick Springs Hotel, French Lick, Indiana—9:30 a.m.

17 Kentucky Society of Anesthesiologists—luncheon meeting—Phoenix Hotel, Lexington

28 Joint Meeting—Districts 1 and 3—Kentucky Dam Village

June

2 Pediatric Postgraduate Course—final session—Children's Hospital, Louisville 9:30 a.m. to 12:30 p.m.

13 Kentucky Society of Pathologists — DuPont Lodge—Cumberland Falls, 3 p.m.—followed by dinner KSMA members invited as paying guests —make reservations

18 Joint meeting — Fourth and Sixth Districts—Mammoth Cave Hotel—4 p.m.

Programs of the University of Louisville School of Medicine (*monthly or weekly*)

Monday

1. Surgical Grand Rounds—Rankin Amphitheater, LGH, 4 p.m.
2. Urological Conference — 3rd Monday — Surgical Conference Room—LGH—4 p.m.

Tuesday

1. Pediatric Case Conference, Children's Hospital Amphitheater, 11 a.m. (10:30 a.m. April 14 through June 2) During school session only
2. Medical Conference (Hematology, Cardiology, Endocrinology, and Gastroenterology, alternating) Rankin Amphitheater LGH, 4 p.m.
3. Orthopedic Case Review, Surgical Conference Room, LGH, 4 p.m.
4. Psychiatric Case Conference, 6th Floor East, Norton Memorial Infirmary, 11 a.m.

Wednesday

1. Gastroenterology Interservice Conference, Medical Conference Room, LGH—12:30 p.m.

Thursday

1. Medical Staff Conference—Rankin Amphitheater, LGH—8 a.m.

2. Clinical Pathological Conference, Rankin Amphitheater—12 noon (during school session only)
3. Urological Conference, Surgical Conference Room, LGH—4 p.m.

Friday

1. Pediatric Staff Conference, Children's Hospital Amphitheater—8 a.m.
2. Psychiatric Case Conference — Child Guidance Clinic, 206 East Chestnut St., Louisville—8:30 a.m.

Saturday

1. Obstetrical Staff Conference—Out-patient Classroom, Second Floor, LGH—8 a.m.
2. Surgical Staff Conference—Rankin Amphitheater, LGH—8 a.m.
3. Gynecology Ward Rounds—LGH—9 a.m.
4. Pediatric Newborn Conference—Pediatric Out-Patient Department, LGH—9:30 a.m.

Dist. 9 to Hold Joint Meeting with KAGP in March

Physicians from the northeastern section of the state are expected to attend the joint seminar meeting of the KSMA's Ninth Councilor District and the Kentucky Academy of General Practice in the Capri Room of Caproni's Restaurant in Maysville on Wednesday, March 25.

Announcement of the meeting was made jointly by J. M. Stevenson, M.D., Brooksville, Councilor from the Ninth District, and Mitchell B. Denham, M.D., Maysville, KAGP program chairman.

Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, and Richardson Noback, M.D., assistant dean of the University of Kentucky School of Medicine, will present the evening program. Speakers in the afternoon session will be Robert C. Wall, M.D., and Joseph Ryan, M.D., Ohio State University College of Medicine; and Eldon Dykes, M.D., and R. C. Britton, M.D., of the Cleveland Clinic.

Wives and physicians attending the meeting will be welcomed by William H. Sewell, M.D., Maysville, president of the Mason County Medical Society.

KPHA Annual Meet in Louisville March 31, April 1-2

Highlights of the 11th Annual Kentucky Public Health Association meeting at the Sheraton Hotel in Louisville on March 31, April 1 and 2 will be addressed by Gaithel Simpson, M.D., Greenville, and Berwyn Mattison, M.D., executive director of the American Public Health Association.

Special features of the convention will be an afternoon of curbstone consultations with experts in the various disciplines of public health and another afternoon of special interest groups on school health, mental health, maternal and child health, public health tax, chronic diseases, and radiological health.

All KSMA members are urged to attend the session at 10 a.m. on April 1 when Doctor Simpson, member of the Governor's Commission on Indigent Medical Care, and Chairman of KSMA Committee on Medical Education and Economies will talk on the development and need of medical care for the indigent in Kentucky and the responsibility that the medical profession and other organizations should assume in this program.

Other speakers and their subjects are: Fred Tosh, M.D., Kansas City Field Station, "The Problem of Histoplasmosis"; Paul Vaal, Director St. Luke Hospital, Poison Control Center, Fort Thomas, "Poison Control Centers in Kentucky"; W. D. Jones, M.D., medical director, District Four TB Hospital, Ashland, "Treatment Trends in Tuberculosis."

Participating in the laboratory section are: Malcolm Barnes, M.D., director clinical laboratories, Norton Memorial Infirmary, Louisville and Morris Scherago, Ph.D., professor of bacteriology and Immuniology, University of Kentucky, who will discuss "The Relationship of the Division of Public Health Laboratories to the Private and Public Laboratory." Milford Hatch, Ph.D., of the Communicable Disease Center, Atlanta, Ga., will talk on "Fluorescein-tagged Antibody Techniques in Rapid Diagnostic Procedures."

Program of Pediatric PG Course Announced by Faculty

The program of the annual Pediatric Postgraduate Course of the University of Louisville Department of Pediatrics at Children's Hospital has been announced by Joseph A. Little, M.D., Louisville, physician-in-chief Children's Hospital. The course is under the direction of A. J. Steigman, M.D., chairman of the Department of Pediatrics.

The program has been accepted by the American Academy of General Practice for 24 hours of Category 1 credit.

Following is the program:

Tuesday, April 14

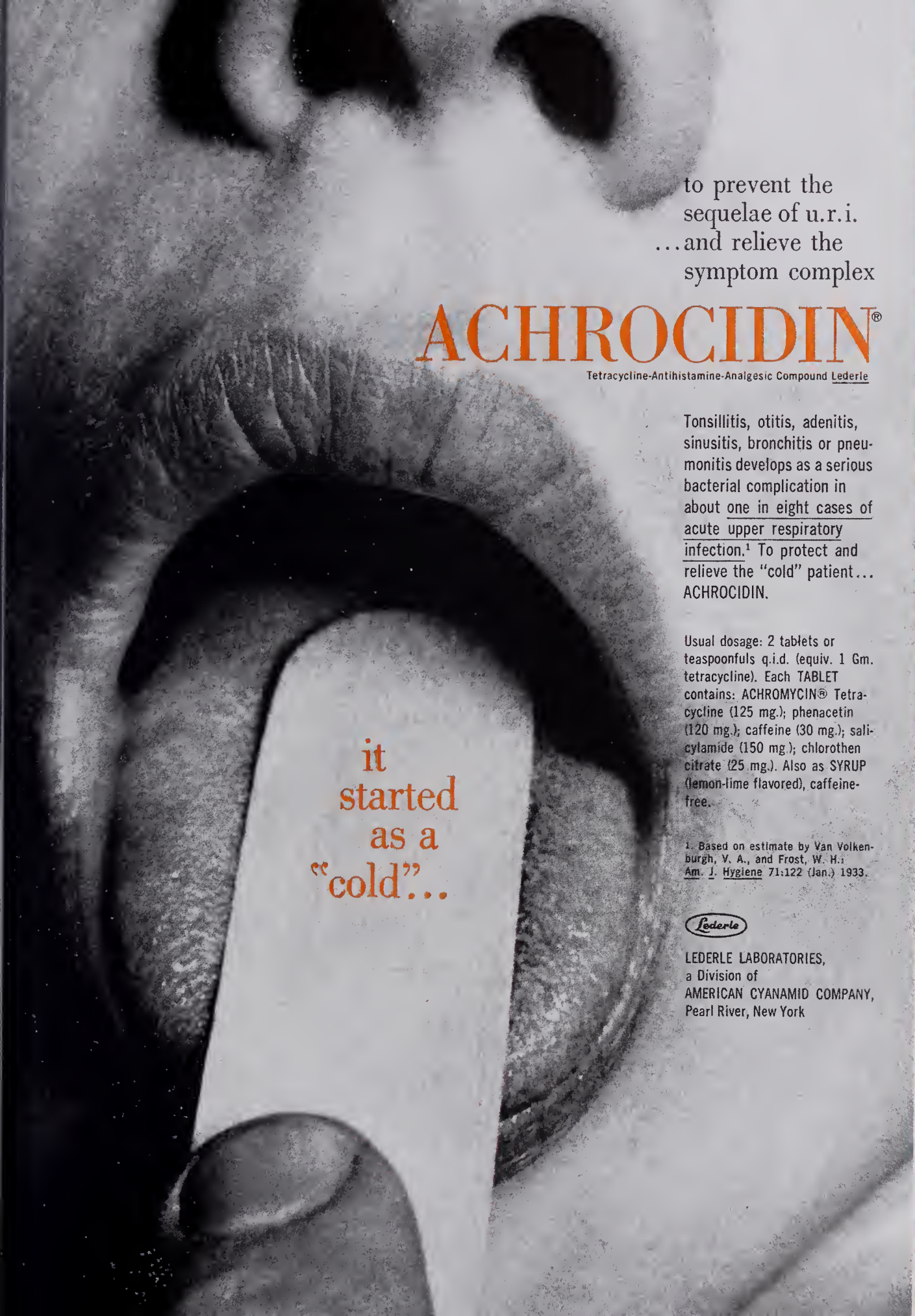
9:30	Welcome, A. J. Steigman, M.D. Comments by State Chairman, AAP, H. S. Andrews, M.D. Chairman PG Committee, KSMA, Walter Coe, M.D.
9:40	*Newer Advances in the Care of the Child with Tuberculosis,* W. C. Adams, M.D.
10:30	Conference
11:30	*The Evaluation of Growth,* Frank Falkner, M.D.

Tuesday, April 21

9:30	*A Practical Approach to Allergy in Childhood,* H. S. Andrews, M.D.
10:30	Conference
11:30	*The Problem of Low Grade Fevers,* J. A. Little, M.D.

Tuesday, April 28

9:30	*Newer Advances in Therapy,* A. J. Steigman, M.D.
10:30	Conference
11:30	*Radiology as a Diagnostic Tool in Pediatrics,* L. A. Davis, M.D., J. A. Little, M.D.



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...and relieve the
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Tonsillitis, otitis, adenitis, sinusitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient... ACHROCIDIN.

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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Pearl River, New York

Tuesday, May 5

9:30	*Symposium—Cancer in Children,* H. B. Lynn, M.D., moderator, L. A. Davis, M.D., I. Diamond, M.D.
	(Discussion and case presentation)
11:30	*Squint,* A. H. Keeney, M.D.
12 noon	*Management of Head Injuries in Children,* E. Grantham, M.D.

Tuesday, May 12

9:30	*Thyroid and Other Endocrine Problems of the Adolescent,* B. T. Towery, M.D.
10:30	Conference
11:30	*Pediatric Gynecology,* D. M. Haynes, M.D.

Tuesday, May 19

9:30	*The Well Child,* Mary Cruise, M.D.
10:30	Conference
11:30	*Medical Care of the Patient with Congenital Heart Disease,* M. B. Vermillion, M.D.

Tuesday, May 26

9:30	*Re-evaluation of Some Common Poisons,* W. C. Adams, M.D.
10:30	Conference
11:30	*Hearing Defects in Children,* A. L. Juers, M.D.
	Activities of the Hearing and Speech Center, Louisville, Wm. Brown

Tuesday, June 2

9:30	*The Newborn,* Katherine Dodd, M.D.
10:30	Conference
11:30	*Question Period,* A. J. Steigman and Faculty

Programming Changes Announced for Annual Meeting

Several departures from the usual annual meeting program format are being scheduled for the 1959 meeting on September 22, 23, and 24, according to Robert W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements.

Specialty group meetings, long an important feature of the annual session, will be held as usual, but are scheduled for Tuesday afternoon, September 22, and Thursday morning, September 24. Six groups will meet each of these days. Past procedure has been for all the specialty groups to meet on Wednesday afternoon.

The change in scheduling was made because the committee desired to make more of the specialty group gatherings available to general practitioners. The Tuesday group meetings will be acceptable to the American Academy for Category 1 credit.

Other features of the 1959 meeting will be two panel discussions, a carefully selected CPC, and the usual high calibre nationally known speakers.

U of L Med. School Library Named For Dr. Kornhauser

The University of Louisville Medical School Lirary has been named the "Kornhauser Memorial Medical Library" in honor of Sidney I. Kornhauser, Ph.D., long-time professor of anatomy and one of the most beloved members of the faculty before his death in January.

The new name which was approved by the University's Board of Trustees was recommended by the Medical School Council and by the Jefferson County Medical Society. The two groups maintain the library jointly. Commenting on the new name Dr. Philip Davidson, U of L president, called it an appropriate tribute to a dedicated person.

J. Murray Kinsman, Medical School dean, said, "The library was close to Dr. Kornhauser's heart. He was closely identified with it and was chairman of the library committee. We feel this is a fitting memorial."

Immunization Week in Kentucky Scheduled May 3-9

The first full week in May (National Child Health Month) has been set aside for "Immunization Week in Kentucky" under the sponsorship of the KSMA and other state-wide organizations, according to Delmas Clardy, M.D., Hopkinsville, who heads the KSMA Committee on Public Health.

Dates of this year's drive for complete immunization of Kentuckians are May 3-9. During the week and in the weeks prior to the drive, the campaign will be promoted extensively through posters distributed by the Association and in newspapers and over radio stations throughout the state.

This year, during the sixth annual Immunization Week, special emphasis is being put on Salk vaccine shots with completion of the full series of shots—plus a booster shot for those who have received all three shots—as the goal for all Kentuckians.

Immunization Week will be featured during May meetings of Homemaker's Clubs, Federated Women's Clubs and other state groups and will stress, besides immunization from polio, immunization from whooping cough, tetanus, and diphtheria.

Dr. Shepherd Announces Candidacy for State Legislature

W. W. Shepherd, M.D., Campbellsville, president of the Taylor County Medical Society and chairman of the Board of Directors of the National Coroners Association, has announced his candidacy as Representative from the 30th District, subject to the May 26 primary.

Doctor Shepherd graduated from the University of Louisville School of Medicine in 1946 and has served as coroner of Taylor County for 10 years.

KSMA President R. W. Robertson, M.D., Paducah, expressed appreciation for Doctor Shepherd's willingness to make the race and indicated that it would be to the advantage of all concerned if more physicians were active in the legislative halls.



Discussing current medical problems during the meeting of the 11th Councilor District at Winchester on February 10 were (left to right): Richard G. Elliott, M.D., Lexington, Councilor for the 10th District; Joe M. Bush, M.D., Mt. Sterling, Councilor for the 11th District; John D. Hummel, Jr., M.D., president of the Clark County Medical Society; Ballard Cassady, M.D., Pikeville, president of the Pike County Medical Society; Charles C. Rutledge, M.D., Hazard, Councilor for the 14th District; and K. Armand Fischer, M.D., Louisville, scientific essayist at the meeting.

Drs. Fischer and Cassady Speak at 11th District Meet

Seventy-five physicians and their wives attended the Eleventh Councilor District meeting in Winchester on February 10, according to Joe M. Bush, M.D., Mt. Sterling, Councilor for that District.

Guests attending the meeting included: Mrs. Jesse Funk, Bowling Green, president of the KSMA Woman's Auxiliary; Charles C. Rutledge, M.D., Hazard, Councilor for the 14th District; and Richard G. Elliott, M.D., Lexington, Councilor for the 10th District.

R. W. Robertson, M.D., Paducah, who was originally scheduled to speak was unable to attend when his flight was cancelled due to bad weather. Scientific portion of the program was presented by K. Armand Fischer, M.D., Louisville. The problems of third party medicine were discussed by Ballard Cassady, M.D., Pikeville. Host group at the meeting was the Clark County Medical Society of which John D. Hummel, Jr., M.D., is president.

Council on Allied Med. Services Elects Officers for '59

The Kentucky Council of Allied Medical Services elected Wade Mountz, Louisville, of the Kentucky Hospital Association, chairman for 1959 at a meeting in Louisville on January 22. Woodford B. Troutman, M.D., Louisville, KSMA secretary, was elected vice chairman. Nelle B. Weller, R.N., Louisville, of the Kentucky State Association of Registered Nurses, is the new secretary.

Also on the agenda of the meeting was a statement of organization and purpose which listed the objectives of the Council as the promotion and encouragement of high professional concepts in all professions; combined efforts to attain maximum educational and ethical standards; and correlation of common interests and activities in the interest of all the professions, the government, and the general public.

The Council is made up of representatives from the KSMA, the Kentucky State Association of Registered Nurses, the Kentucky State Dental Association, the Kentucky State Hospital Association, and the Kentucky Pharmaceutical Association.

Annual meeting of the Council will be held annually in November and additional meetings will be called by the chairman. Elections of officers will take place at that time.

KSMA Purchases Film, "Med. Man" for Public Health Library

Two copies of the film, "The Medicine Man," produced by the American Medical Association which depicts food fads and the dangers inherent in them, was recently purchased by the KSMA and given to the film library of the State Department of Health.

The Committee on Public Information and Service recommended purchase of the film and its recommendation was approved by the Council of the KSMA.

Nathaniel L. Bosworth, M.D., Lexington, requests all members to tell all interested groups about the film and that it is available from the film lending library of the State Department of Health, 620 South Third St., Louisville. It is suitable for television as well as showing to local group meetings.

Sectional Urological Meet Set

About 400 physicians are expected to attend the meeting of the Southeastern Section of the American Urological Association at the Brown Hotel in Louisville from March 29 to April 2.

Announcement of the meeting was made by Robert Lich, Jr., M.D., Louisville, who is program chairman of the meeting. The section is made up of ten southeastern states, including Kentucky.



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STUDENT AMA

Education and Dr. Kornhauser

On the first day of this year there died in Louisville a man whose life epitomized the goals of a truly professional man—he was, of course, S. I. Kornhauser, a teacher. He was one of those persons who could retain in his philosophy the best of the past while continually adding to his life from the myriad of new ideas. Early in the 1920's he was forced to leave the religious college where he taught because he refused to compromise his scientific beliefs (those in question being the theories of evolution by natural selection). Thus he came to Louisville.

His life was one rich in the rewards of a brilliant scientist, but further, he participated fully in the cultural and educational life of his school and community. As a teacher he maintained the tradition that his field of interest was a discipline and as such commanded the respect and strict application of the student. He never failed to introduce those techniques which facilitated the learning process but, as anyone who has ever taken his exams can attest, he believed that there was no substitute for well organized, individual study.

With the increasing complexity of the world around us and in particular, that quasi-world of science, we are faced with a growing demand for trained personnel to serve the needs of society. Society is, however, an impatient mistress, and notably lacking in insight. Since there seems to be a shortage of certain types of workers, the obvious answer (to society) is to train more in a shorter time. The ultimate in this rationalization is to be found in Russia where the physician is regarded as a highly-skilled maintenance man whose province is the human machine.

The hue and cry has been raised in America to produce more M.D.'s. The most commonly heard program involves cutting the pre-medical years to a bare minimum (2 years, in most circles), almost exclusively composed of physics, mathematics, chemistry, and biology—with public speaking thrown in for good measure. This would be fine if the desired product were to be a mechanic, but the human body is least of all a machine and the physician, to my understanding, spends but a small part of his "therapeutic time" in correcting the actual organic ills of his patients. Thus the physician must have a broad background of experience and interest to draw upon when attempting to evaluate and help the patient who happens to be a cognizant human being. Maturity, and the trial and hardship which leaven its formation, are integral parts of this experience and cannot be gained except by dint of time and effort.

The point here is discipline. The student of medicine is inevitably a student of life, and life is not solely a thing of science, hence the famous dichotomy —the art and science of medicine. The student of medicine must apply himself rigorously to both halves, he must discipline himself so that neither side of the totality predominates over the other. Perhaps this is why, among the best physicians, one is often surprised at the humanity of the gruffest, most objective man and the scientific acumen of the sympathetic, most naive individual. Perhaps this is also the reason that the medical training period must be so long; long enough to allow the student to learn two ways of life and to combine them into a working philosophy which will serve himself and humanity.

These were the principles which guided Dr. Kornhauser's teaching—always encouraging the student to take time out to enjoy something worthwhile, yet never relaxing the high standards which he set for himself and his students. He was, a Teacher.

Neville Caudill
Pres., U. of L. Chapter, SAMA

March is Red Cross Month

"The Red Cross—On the Job When You Need It Most" is the theme of the 1959 Red Cross campaign conducted during the month of March to enlist active participation and financial support of its nation- and world-wide activities.

Besides its more familiar responsibilities—those of disaster relief, collecting of blood, training in first aid, water safety, and home nursing—in 1958 the Red Cross also secured the release of nine American servicemen held by the East Germans for six weeks and put Red Cross field directors ashore with the U. S. Marines and Army in Lebanon.

KAGP Moves to Louisville

The Kentucky Academy of General Practice was scheduled to move its headquarters office from Cincinnati to the Medical Arts Building in Louisville about March 1.

A new executive secretary, not yet chosen as the Journal went to press, will be employed. For the past four years Clayton L. Scroggins, who heads a business-management firm in Cincinnati, has served the KAGP office. Scroggins said he agreed to serve at a time when the Academy needed help, but now it is "strong and financially solvent and can maintain its own headquarters."

Cancer Conf. in Denver, July 22-3

KSMA members who have attended the Rocky Mountain Cancer Conference in the past will be interested to know that the next conference will be held July 22-23 in the Brown Palace Hotel, Denver, which has a new 250-room addition and is completely air-conditioned.

N. Paul Isbell, M.D., Denver, states that the Conference will present an outstanding program by guest speakers of national reputation. Those interested in making reservations should get in touch with John W. Pompelli, Colorado State Medical Association (one of the co-sponsors of the Conference), 835 Republic Building, Denver 2, Colorado.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1959 Annual Meeting — Kentucky State Medical Association

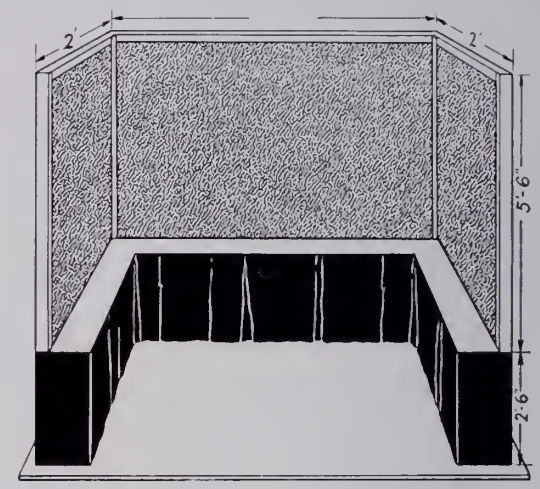
Columbia Auditorium — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

EVERETT L. PIRKEY, M.D., Chairman
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

Applications for space should be received before July 1, 1959

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

"the most critical inspection yet devised for an eye-glass lens"--

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GUILD OPTICIANS

SPECIAL ARTICLE

(Continued from page 320)

and me—must accept at least part of the blame for this drought in the grass roots. Relief is in sight only if every physician—not a select few—but every physician, turns on the sprinkling system of person-to-person contact.

Then—and only then—can the nourishing waters of personal interest, of factual information and of considered judgment strengthen the legislative representative in what is right and just for medicine and public health.

McDowell Home Receives Donation

The Council of the Southern Surgical Association has forwarded a check for $200 to the McDowell Home Fund for the year 1959. Presentation was made by George D. Lilly, M.D., Treasurer of the Southern Surgical Association. The KSMA McDowell Home Committee has expressed appreciation for this contribution, which is to be applied on maintenance expenses of the home.

Dr. Francis Heads Anesthesiologists

Lewis Francis, M.D., Lexington, was installed as president of the Kentucky Society of Anesthesiologists at a meeting in Louisville on January 15. Other officers of the Society, all from Louisville, are: Warren Ash, M.D., president-elect; George Shaffer, M.D., vice president; Marvin Bowers, M.D., secretary-treasurer. The retiring president is James R. Flautt, Jr., M.D., Louisville.

Trauma Course Planned in April

All phases of trauma will be discussed by leading physicians in the Chicago area and distinguished guest speakers from other parts of the country at the third annual Postgraduate Course in Fractures and Other Trauma in Chicago on April 15-18. The program will be presented by the Chicago Committee on Trauma of the American College of Surgeons.

AAGP to Meet in San Francisco

The American Academy of General Practice will hold its 11th Annual Scientific Assembly from April 6-9 in San Francisco's Civic Auditorium. Featured on the scientific program will be 28 prominent physician-authorities.

More than 7,000 physicians and guests are expected to attend the meeting, which will also offer more than 100 scientific and 300 technical exhibits. The Congress of Delegates, the Academy's policy-making body will convene in the Fairmont Hotel on Saturday, April 4. They will also meet until noon, Monday, April 6, when the scientific sessions open in the auditorium.



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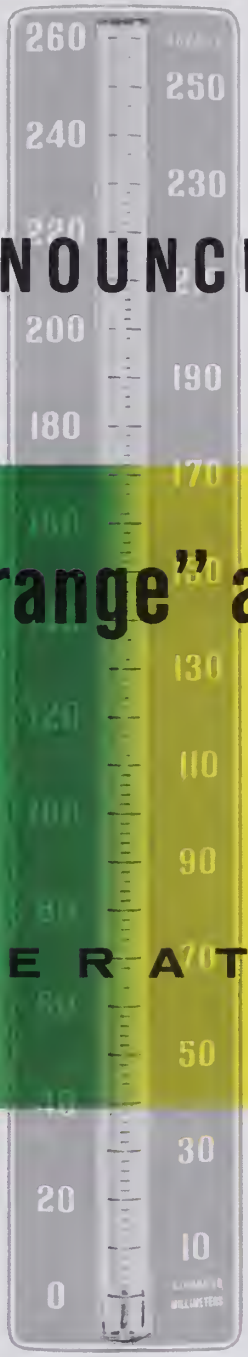
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Thiamine HCl (B_1)	10 mg.
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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.

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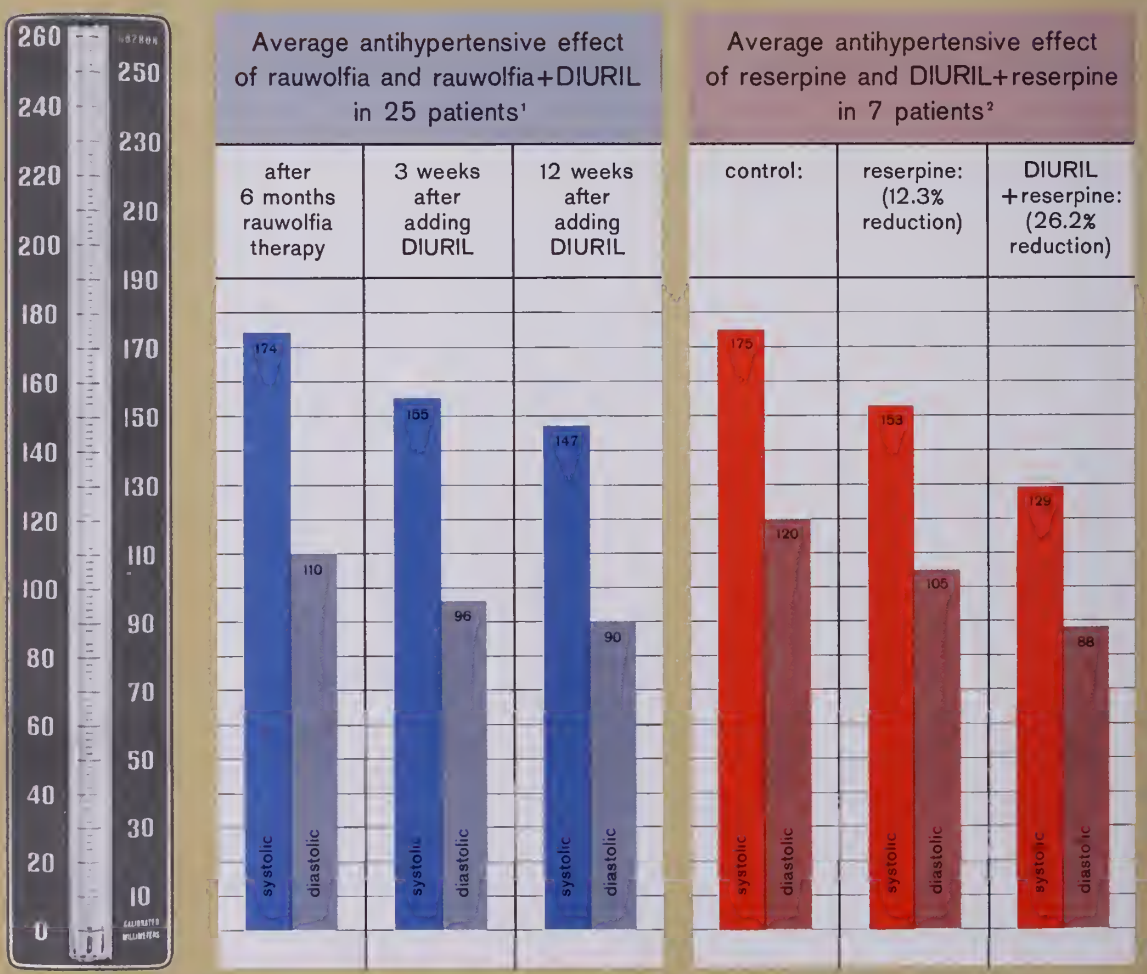
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with DIUPRES than with any other agent
...with greater simplicity and convenience

a logical alliance of two antihypertensives you know and trust provides

increased effectiveness, decreased side effects

potentiated effect

DIUPRES produces an effect greater than either DIURIL or reserpine alone. It is effective in many patients who respond inadequately or not at all to either DIURIL or reserpine.



DIUPRES

DIURIL® WITH RESERPINE

effective therapy for most patients

DIUPRES by itself usually provides effective therapy for a majority of patients with mild or moderate hypertension, and even for many patients with severe hypertension. Many patients now treated with other agents which frequently cause distressing side effects can be adequately managed with well tolerated DIUPRES.

provides basic therapy

Should other drugs need to be added to DIUPRES, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced.

rapid onset of effect

The antihypertensive action of DIUPRES is rapidly evident. (Considerable time may elapse before the antihypertensive effect of reserpine alone is observed.)

fewer and less severe side effects

DIUPRES may be expected to cause fewer and less severe side effects than are encountered with other antihypertensive therapy. (Since DIURIL and reserpine potentiate each other, the required dosage of each is usually less when given together as DIUPRES than when given alone. Such reduction in dosage makes side effects less likely to occur.)

often obviates weight gain

DIUPRES minimizes the problem of weight gain seen with reserpine (reserpine alone has been reported to produce weight gain in 50 per cent of patients).[1,4]

virtually eliminates fluid retention

DIUPRES is not likely to cause either clinical or subclinical retention of sodium and water. (Hypotensive drugs, particularly rauwolfia[5] and hydralazine,[6] may cause fluid retention. Even when such retention is subclinical, their antihypertensive effectiveness is diminished.[6])

diet more palatable

With DIUPRES, there is less need for rigid restriction of dietary salt, which patients find so burdensome.

> *"It may well be that the drug* [DIURIL] *produces the benefits of a markedly restricted low sodium diet but without its hardships."*[3]

subjective and objective improvement

DIUPRES allays anxiety and tension, thus reducing the emotional component of hypertension. Organic changes of hypertension may be arrested and reversed. Headache, dizziness, palpitations and tachycardia are usually promptly relieved by DIUPRES. When the *anginal syndrome* accompanies hypertension, the administration of DIUPRES may also cause diminution or even disappearance of this syndrome concurrent with control of the hypertension.

convenient, controlled dosage

Instead of two separate prescriptions, you write one prescription . . . the patient takes one tablet, rather than two different tablets . . . and the dosage schedule is easier for the patient to remember and follow.

> *"patients have fewer lapses and make fewer mistakes in dosage, the simpler the regimen can be made. Therefore I do not hesitate to use more than one medicament combined in one tablet, provided this gives approximately the correct dosage of each."*[6]

economical

DIUPRES will cost the patient less than if he were given two separate prescriptions for its components.

Indications:

DIUPRES is indicated in hypertension of all degrees of severity. It can be used in the following ways:

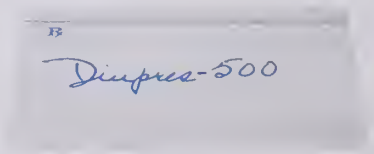
- as total therapy
- as primary therapy, adding other drugs if necessary
- as replacement or adjunctive therapy in patients now treated with other agents

Precautions:

The precautions normally observed with DIURIL or reserpine apply to DIUPRES. Additional information on DIUPRES is available to physicians on request.

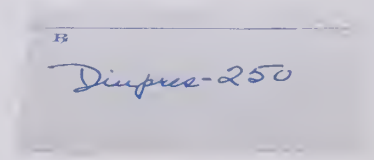
Recommended dosage range:

DIUPRES-500—one tablet one to three times a day.
DIUPRES-250—one tablet one to four times a day.
If necessary, other agents may be added.
If the patient is receiving ganglion blocking agents or hydralazine, their dosage should be cut by 50 per cent when DIUPRES is added.



DIUPRES-500

500 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.



DIUPRES-250

250 mg. DIURIL (chlorothiazide), 0.125 mg. reserpine.
Bottles of 100, 1000.

the first "wide range" antihypertensive

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1. Rochelle, J. B., III, Bullock, A. C., and Ford, R. V.: Potentiation of antihypertensive therapy by use of chlorothiazide, *J.A.M.A.* 168:410, Sept. 27, 1958. 2. Freis, E. D., Wanko, A., Wilson, I. M., and Parrish, A. E.: Treatment of essential hypertension with chlorothiazide (Diuril), *J.A.M.A.* 166:137, Jan. 11, 1958. 3. Freis, E. D.: Treatment of hypertension. (Presented at the Annual Meeting of Southern Medical Association, Nov. 13, 1957.) 4. Moyer, J. H., Dennis, E., and Ford, R.: Drug therapy (Rauwolfia) of hypertension, *A.M.A. Arch. Int. Med.* 96:530, Oct. 1955. 5. Perera, G. A.: Edema and congestive failure related to administration of rauwolfia serpentina, *J.A.M.A.* 159:439, Oct. 1, 1955. 6. Wilkins, R. W.: Precautions in use of antihypertensive drugs, including chlorothiazide, *J.A.M.A.* 167:801, June 14, 1958.

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In Memoriam

ROBERT G. BLACKWELDER, M.D.
Hopkinsville
1891-1959

Robert G. Blackwelder, M.D., superintendent of Western State Hospital, died of a heart attack on February 1 at the age of 68.

A native of Concord, N. C., Doctor Blackwelder graduated from the Medical College of Virginia in 1932. He took his internship training at Chesapeake and Ohio Hospital in Huntington, West Virginia. He had been superintendent at Western State since 1957.

WILLIAM K. DUDLEY, M.D.
Lexington
1878-1959

William K. Dudley, M.D., retired physician and farmer, died at St. Joseph Hospital in Lexington on January 17. He had been there for treatment for 10 days.

Doctor Dudley was a native of Bourbon County and attended Bourbon County Schools. He graduated from the University of Louisville Medical School in 1904.

WILLIAM GERDING, M.D.
Newport
1873-1959

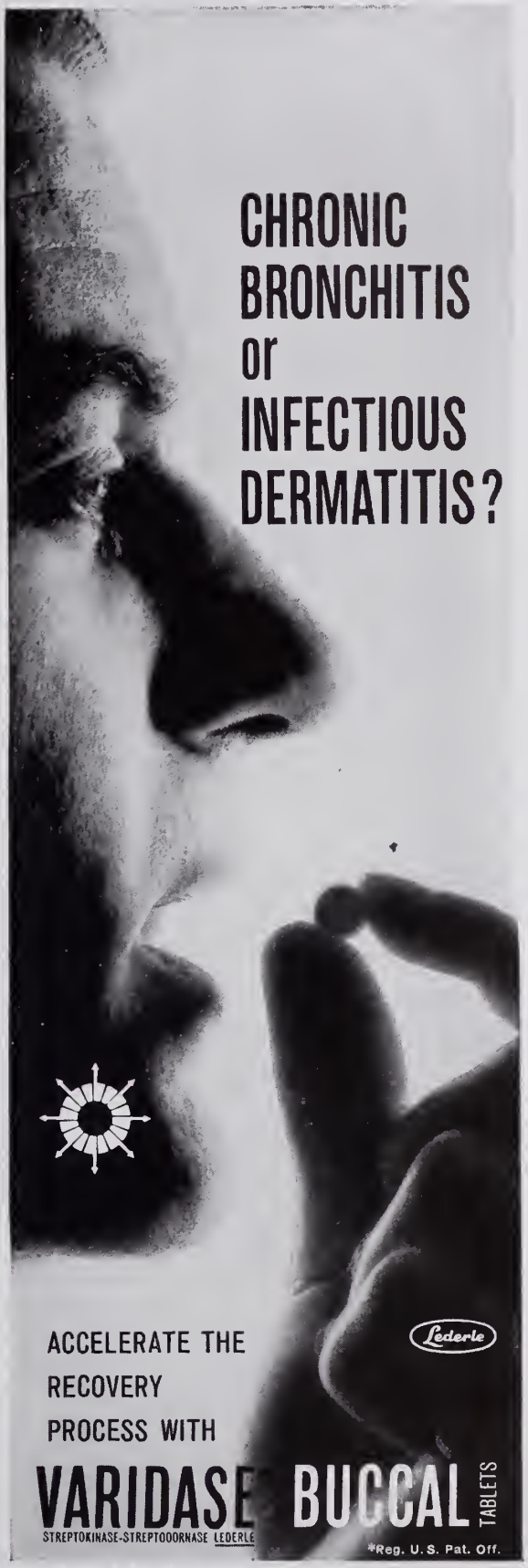
William Gerding, M.D., who had practiced in Newport for 62 years prior to his retirement five years ago, died at St. Elizabeth Hospital in Covington on January 22. He was 85.

Doctor Gerding was a former president of the St. Elizabeth Hospital staff and had served on the staff until 1938 when he was made an emeritus staff member. He graduated from the Ohio College of Pharmacy in 1893 and from the Ohio College of Medicine in 1897.

ROY ORSBURN, M.D.
Sebree
1879-1959

Roy Orsburn, M.D., Sebree, a veteran of 32 years with the Kentucky Public Health Service, died at his home after a long illness on February 5.

Son of the late George Orsborn, M.D., who practiced in Webster County, he was a graduate of the University of Louisville School of Medicine in 1910. He started practice in Webster County in 1913 and after 14 years of private practice, he entered the Public Health Service in 1927, serving in Webster, Muhlenburg, Fleming, Garrad, Lincoln, Simpson, Allen, and Marion counties. He returned to his home in Sebree following his retirement in 1954.



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H. HALBERT LEET, M.D.
Lexington
1911-1959

H. Halbert Leet, M.D., died in the crash of his private four-passenger plane in Woodford County on January 26 while flying from Pineville to Lexington. Three other men were flying with Doctor Leet and were also killed when the plane crashed.

Doctor Leet, a psychiatrist, had operated a clinic in Lexington since 1950. A native of Lexington, he graduated from the University of Louisville School of Medicine in 1937. At one time he was part-time clinical director at Eastern State Hospital, an assistant professor at the University of Kentucky and the University of Cincinnati, and a lecturer at Tulane University, and later president of the Wayside Hospital at Lexington. From 1942-46, he was in the Army Medical Corps with the rank of lieutenant colonel.

County Society Reports

Harlan

The January meeting of the Harlan County Medical Society was held jointly with the Harlan County Bar Association, according to William H. Anderson, M.D., secretary of the Society. The program was built around a panel discussion of problems of mutual concern to attorneys and physicians.

Physicians participating in the panel included: William H. Potter, M.D., William H. Anderson, M.D., David McL. Greeley, M.D., and William N. Smith, M.D.

As a result of the meeting, according to Doctor Anderson, it is anticipated that both the Society and the Harlan County Bar Association will appoint a standing committee to meet periodically for the purpose of discussion and solution of problems common to both professions. It is also anticipated that both organizations will adopt the National Interprofessional Code for Physicians and Attorneys.

McCracken

The December meeting of the McCracken County Medical Society was held in Boswell's Restaurant. Charles Harting, M.D., vice president, presided.

Copies of the finance report for 1957 and 1958 were presented to the members and accepted.

Doctor Higdon proposed that a committee draw up a resolution on the deaths of Doctors Frank Boyd and E. W. Jackson. Serving on this committee are: Leon Higdon, M.D., R. W. Robertson, M.D., and J. Vernon Pace, M.D.

A motion was made and passed to allocate $100 annually to the secretary to dispense with as he sees fit in properly carrying out the duties of his office.

It was announced that there was no longer any polio vaccine available at the Health Department for the vaccination of indigent patients. A motion was made and passed that each doctor assume the responsibility of vaccinating ten indigent patients at his own expense.

Another motion was passed that every doctor use only one listing in the classified section and if there is a desire for multiple listing, this would be cleared by the secretary.

Officers were elected for the coming year and were listed in the February issue of the Journal.



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Mysteclin-V strikes directly at all tetracycline sensitive organisms—most pathogenic bacteria, certain large viruses, Endamoeba histolytica. It provides all benefits of tetracycline in the effective phosphate complex form.[1] Patient response is rapid because initial high peak blood serum levels may be maintained easily at the antibacterial attack level until the infection is conquered.

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Half-strength Capsules (125 mg./125,000 u), bottles of 16 and 100.
Suspension (125 mg./125,000 u per 5 cc.), 2 oz. bottles.
Pediatric Drops (100 mg./100,000 u per cc.), 10 cc. dropper bottles.

References: 1. Crunk, G. A.; Naumann, D. E., and Casson, K.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia Inc. 1958, p. 397 • 2. Newcomer, V. D.; Wright, E. T., and Sternberg, T. H.: Antibiotics Annual 1954-1955, New York, Medical Encyclopedia Inc., 1955, p. 686.

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Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazone 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

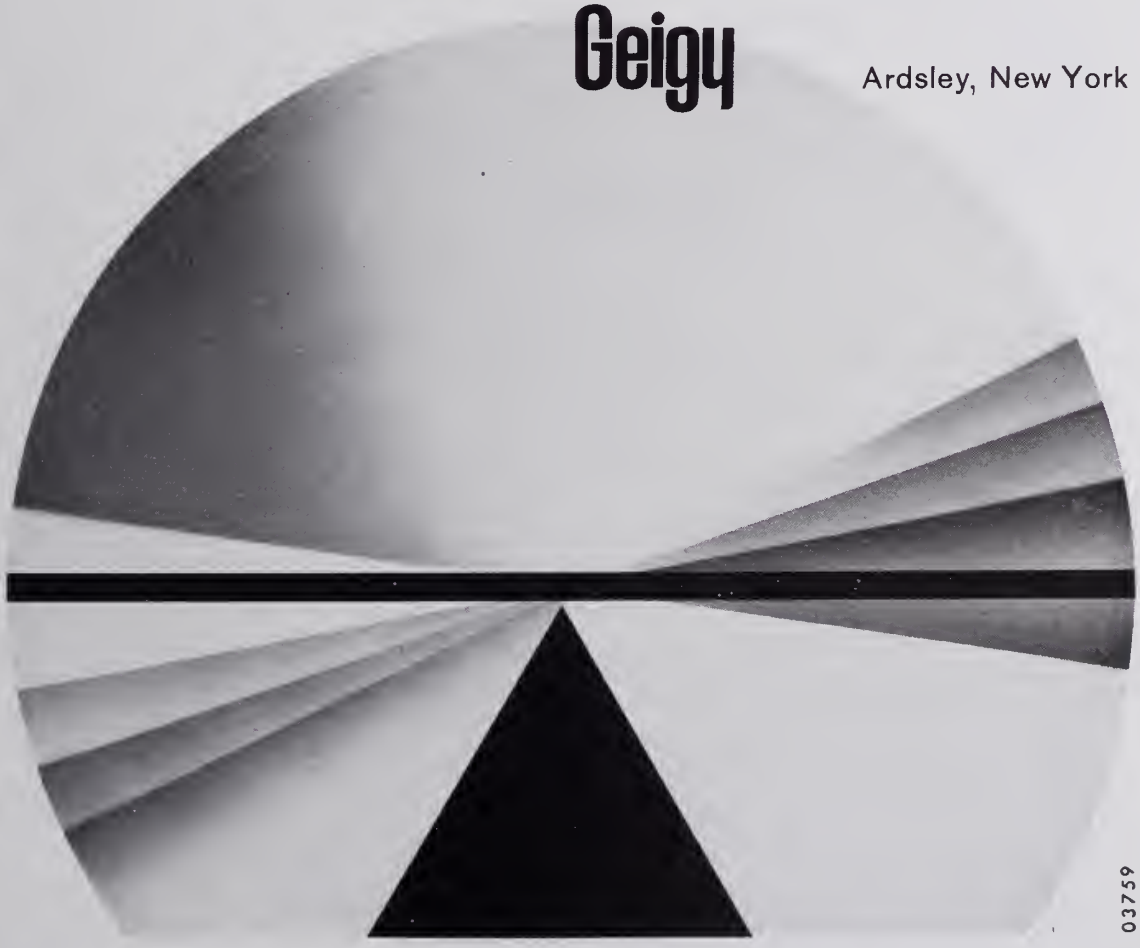
Detailed information available on request.

*Geigy's trademark for phenylbutazone—Reg. U. S. Pat. Off.

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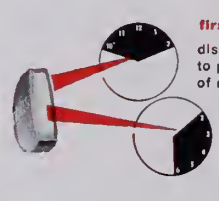
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safer and more effective than topical medication

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Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

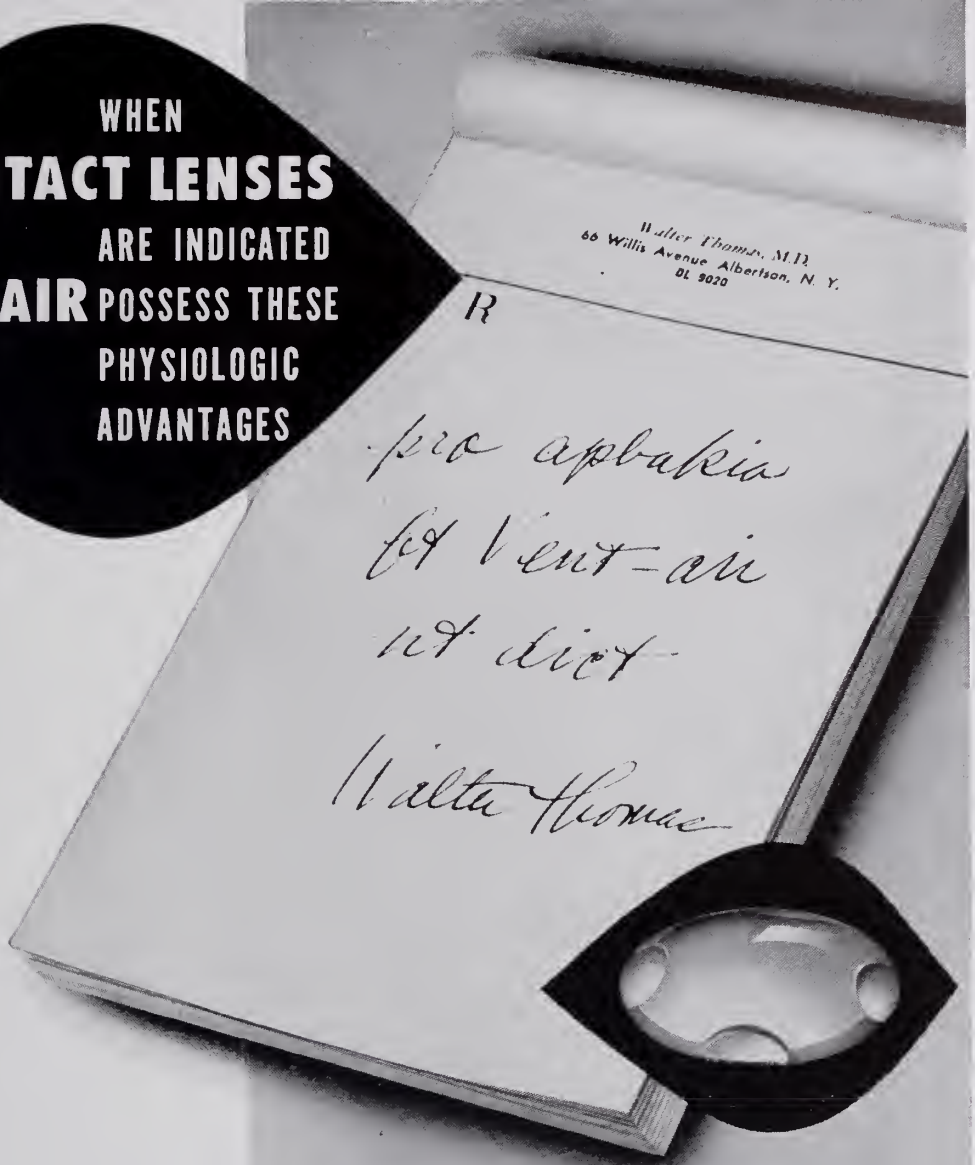
Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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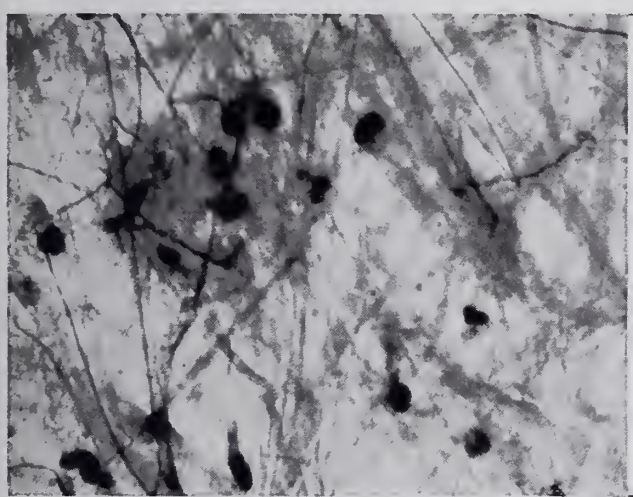
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The possibility of gastric distress from either salicylamide or corticosteroid is minimized because of lower dosage required. This is further reduced by the buffer action of aluminum hydroxide. And the ascorbic acid helps meet the increased need for this vitamin in stress conditions. Because of the low dosage, side effects with Aristogesic have been relatively infrequent and minor in nature. However, more serious side effects have traditionally been observed on all corticosteroid therapy. Patients on long-term Aristogesic therapy should, therefore, be observed carefully.

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for relief of *chronic*—but *less severe* pain of rheumatic origin



Indications: Mild cases of rheumatoid arthritis, tenosynovitis, synovitis, bursitis, mild spondylitis, myositis, fibrositis, neuritis and certain muscular strains.

Dosage: Average initial dosage: 2 capsules 3 or 4 times daily. Maintenance dosage to be adjusted according to response.

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ARISTOCORT® Triamcinolone . . . . . 0.5 mg.
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calms the patient under stress

Rautensin provides a smooth, gradual and sustained reduction of blood pressure without sudden rebounds or abrupt declines.[1] Rautensin's tranquilizing properties calm the tense and anxious hypertensive without impairing alertness, without producing excessive lethargy or drowsiness.

The risk of Rauwolfia-induced depression is markedly reduced since the alseroxylon fraction alone is used.[2] Even on long-term administration side actions "...are either completely absent or so mild as to be inconsequential."[3]

Rautensin®

Each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

1. Wright, W. T., Jr.; Pokorny, C., and Foster, T. L.: Kansas M. Soc. *57*:410, 1956. 2. Gilchrist, A. R.: Brit. M. J. *2*:1011 (Nov. 3), 1956. 3. Terman, L. A.: Illinois M. J. *3*:67, 1957.

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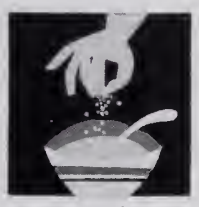
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SQUIBB MULTIPLE VITAMIN SOFT TABLETS

fruit-punch flavored tablets that will actually "melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



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VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth.* Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good.* These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B_1, B_2, niacinamide and C, and significant amounts of other essential vitamins.

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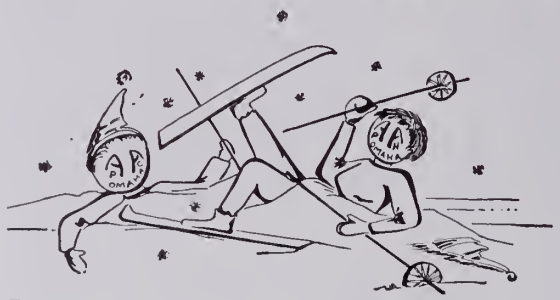
Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C	75 mg.
Vitamin B_1	3 mg.
Vitamin B_2	3 mg.
Vitamin B_6	2 mg.
Niacinamide	25 mg.
Calcium Pantothenate	3 mg.
Vitamin B_{12}	5 mcg.

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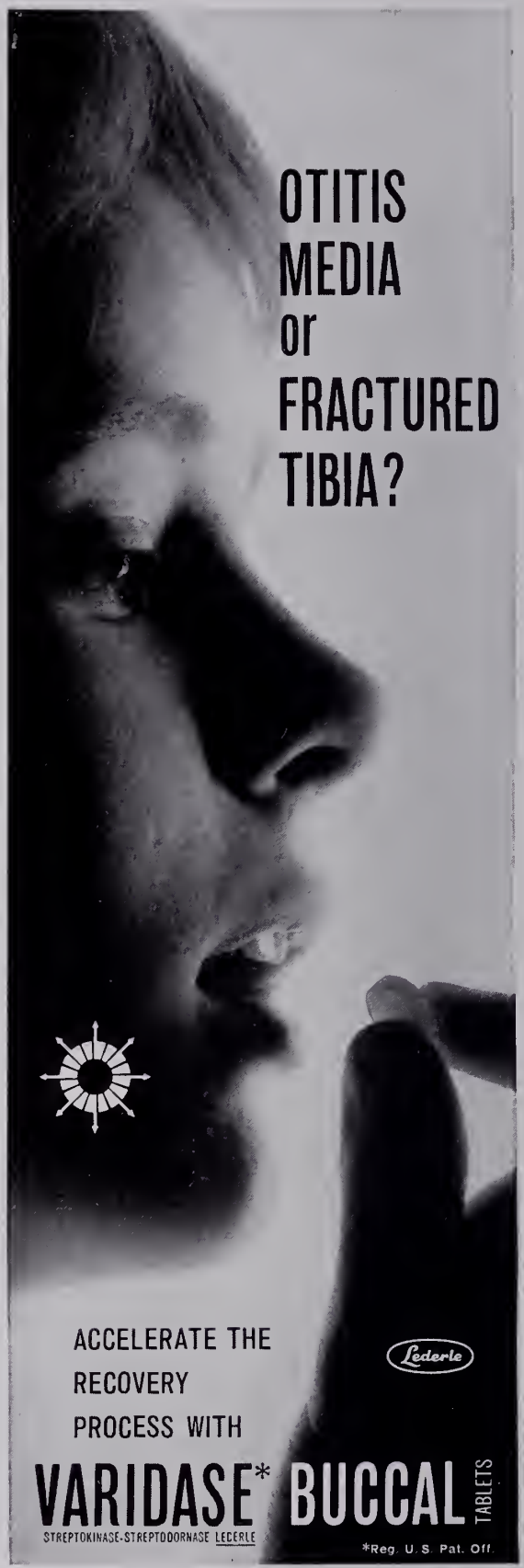
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NEWS ITEMS

John F. Ice, M.D., a 1953 graduate of George Washington University School of Medicine, is practicing psychiatry at the Child Guidance Clinic in Louisville. Doctor Ice, whose wife, Inez, is currently resident in psychiatry at Norton Infirmary, interned at the U. S. Public Health Service Hospital in Seattle, Washington and took his residency training at the U. S. P. H. S. Hospital in Lexington.

W. E. Davis, M.D., who has been in general practice for the past 20 years in North Middletown, is giving up his active practice to become health officer for Bourbon, Harrison, and Scott counties. He plans to take over his duties after a trip to England.

If one . . . or all . . . needs nutritional support . . .



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deserve

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capsules—14 VITAMINS AND 11 MINERALS

For Complete Formula see PDR (Physicians' Desk Reference), page 689

Vitamin-Mineral Supplement Lederle

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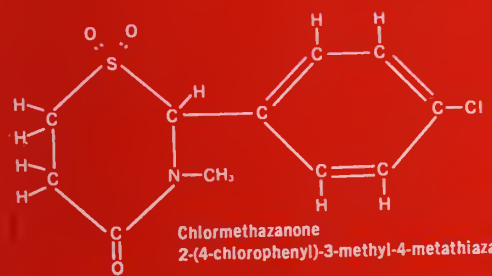
Trancopal®

the first true tranquilaxant

Potent MUSCLE RELAXANT

and equally effective

as a TRANQUILIZER



Chlormethazanone
2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Unrelated chemically to any other therapeutic agent in current use. Better tolerated and safer than older drugs.

for clinical results in 4092 patients

see inside

Trancopal

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*TRANQUILAXANT**

***Potent* MUSCLE RELAXANT**
***and equally effective as a* TRANQUILIZER**

clinical results in 4092 patients[5]

***tran-qui-lax-ant** (tran'kwi-lak'sant)
[< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]

Clinical Comments

"We have just started using it [Trancopal] for relaxing spastic musculature and are *very much encouraged.*"[1]

Baker, University of Minnesota Medical School

"Chlormethazanone [Trancopal] not only relieved *painful muscle spasm*, but allowed the patients to resume their normal activities with no interference in performance of either manual or intellectual tasks."[2]

Lichtman, New York Polyclinic Medical School and Hospital

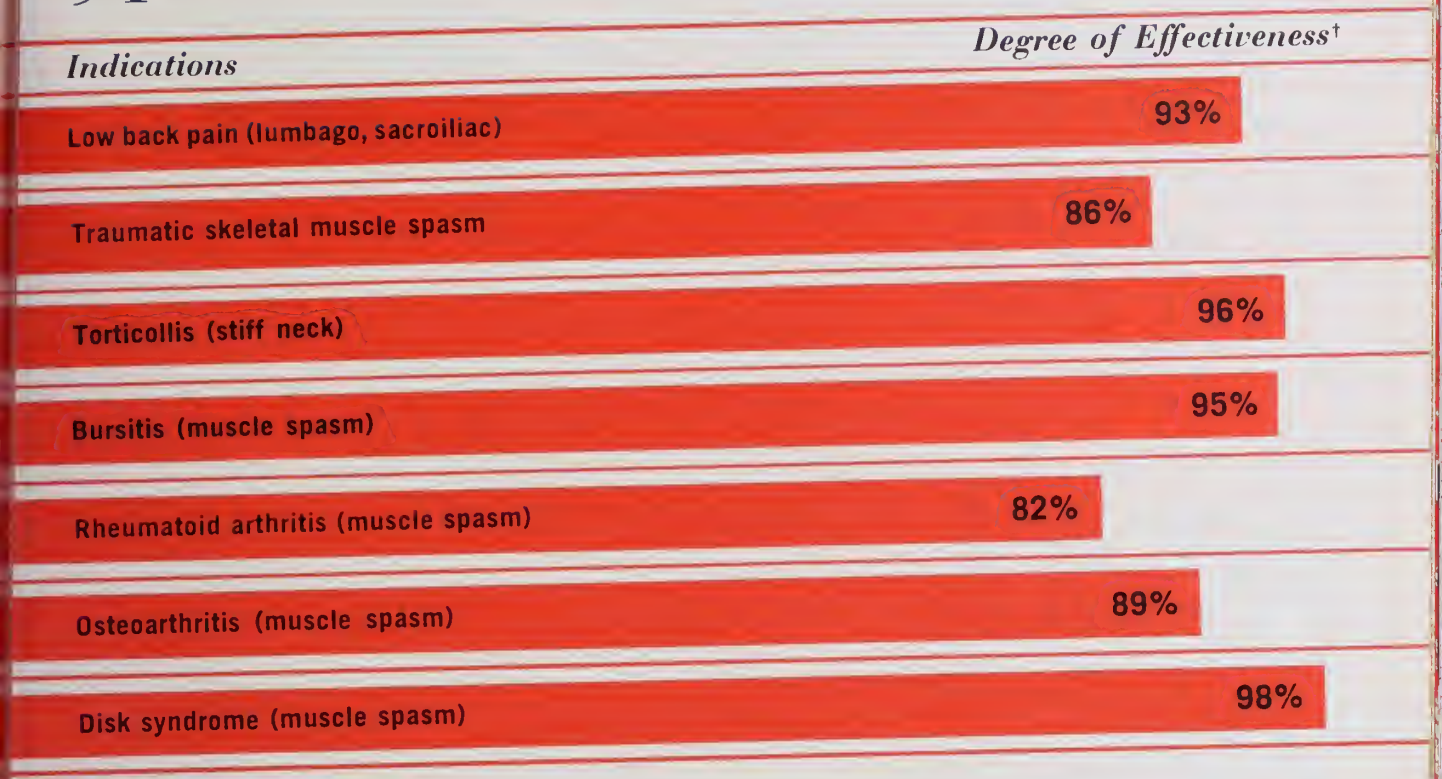
"The effect of this preparation in these cases [skeletal muscle spasm] was *excellent and prompt . . .*"[3]

Mullin and Epifano, Long Island College Hospital

"In 120 patients with *anxiety or tension states*, 114 received satisfactory control of their condition. *Severe dysmenorrhea* and *premenstrual tension* in 65 patients refractory to the usual medications were relieved satisfactorily in 56."[4]

Lichtman

91% Effective in Musculoskeletal Disorders



89% Effective in Psychogenic Disorders



†*Excellent, good and fair*

The results of clinical studies of over 4092 patients by 105 physicians demonstrate that Trancopal often is effective when other drugs have failed. From these studies it is clear that Trancopal probably can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than any other pharmaceutical agent in current use.

Winthrop

Dosage:
Usual adult dose, 1 Caplet (100 mg.) three or four times daily. Children (from 5 to 12 years), ½ Caplet (50 mg.) three or four times daily.

Supplied:
Trancopal Caplets® (peach colored, scored) 100 mg., bottles of 100 and 1000.



Trancopal

the first true tranquilaxant

Potent MUSCLE RELAXANT
and equally effective
as a TRANQUILIZER

ADVANTAGES OF TRANCOPAL

- Lower incidence of side effects than with zoxazolamine, methocarbamol or meprobamate.
- No known contraindications. Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- Low toxicity.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.
- No perceptible soporific effect, even in high dosage.

INDICATIONS

Musculoskeletal
Low back pain (lumbago)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disk syndrome
Fibrositis
Joint disorders (ankle sprain, tennis elbow, etc.)
Myositis
Postoperative myalgias

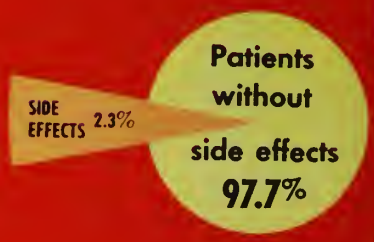
Psychogenic
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris

Neurologic
Muscle spasm (in paralysis agitans, multiple sclerosis, hemiplegia, cerebral palsy)

SAFETY



Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe, or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4262 PATIENTS.

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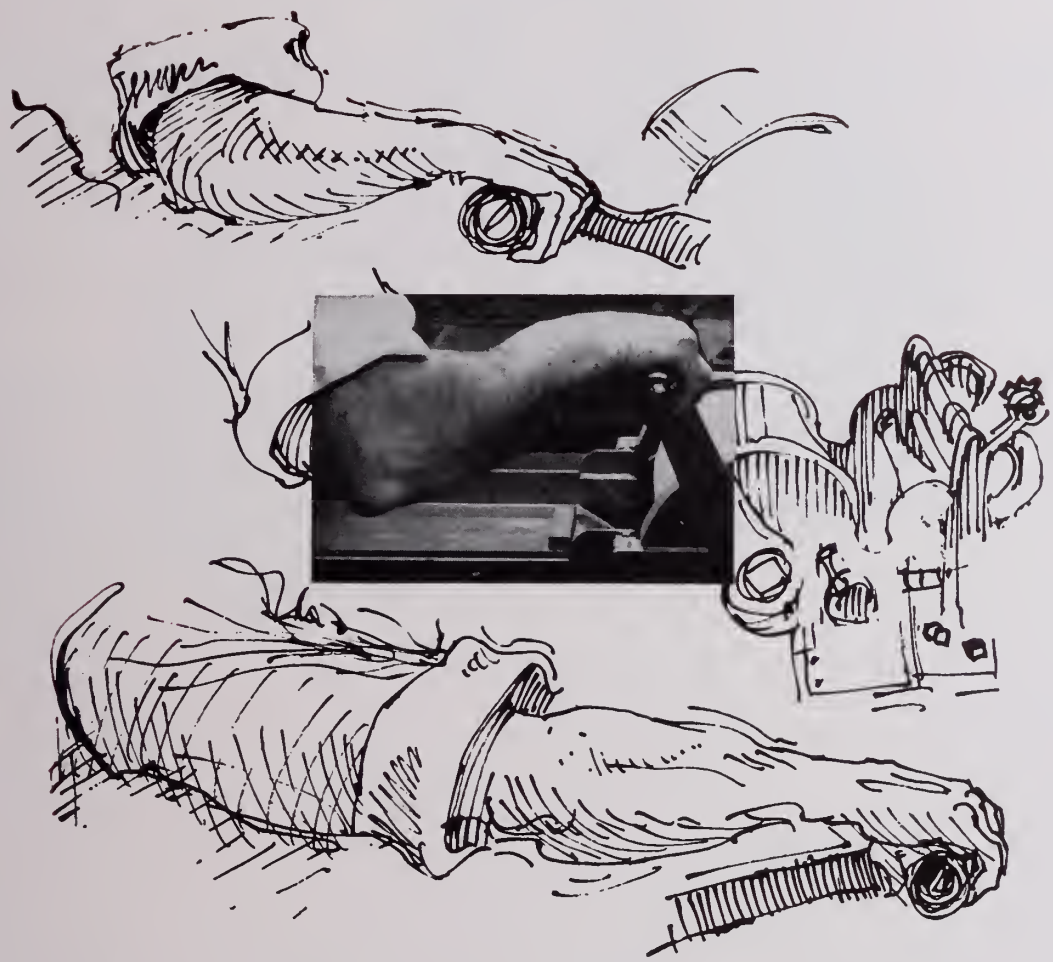
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To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

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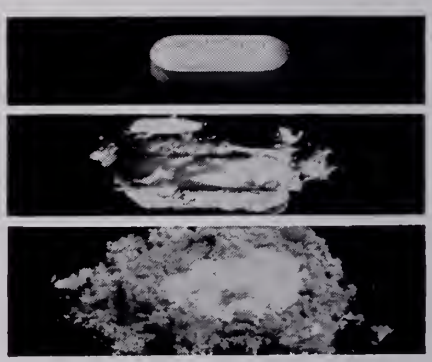
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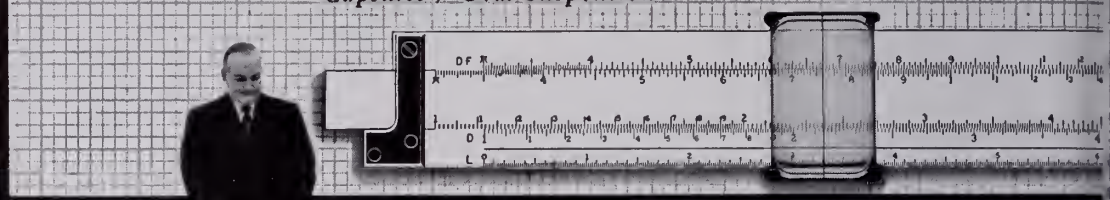
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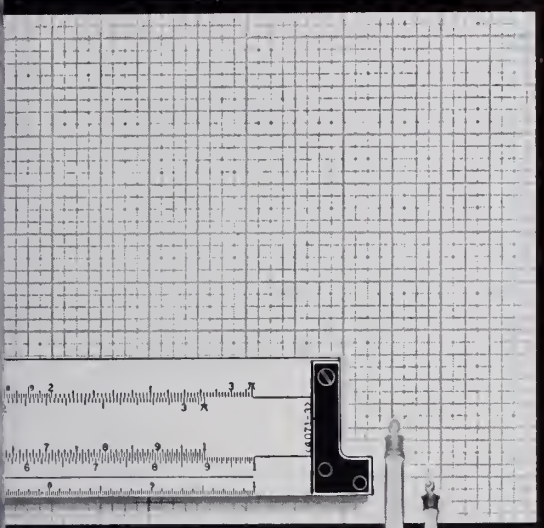




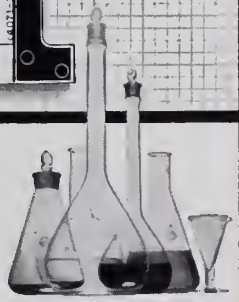
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95% effective in published cases[1-8]

Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	–	6
Otitis media	31	29	2	–
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	–
Abscesses	51	43	8	–
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	–
Pyoderma	19	19	–	–
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	–
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	–
Urethritis with gonorrhea or cystitis	8	8	–	–
Pyelonephritis	4	1	–	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	–	–
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	42	30	8	4

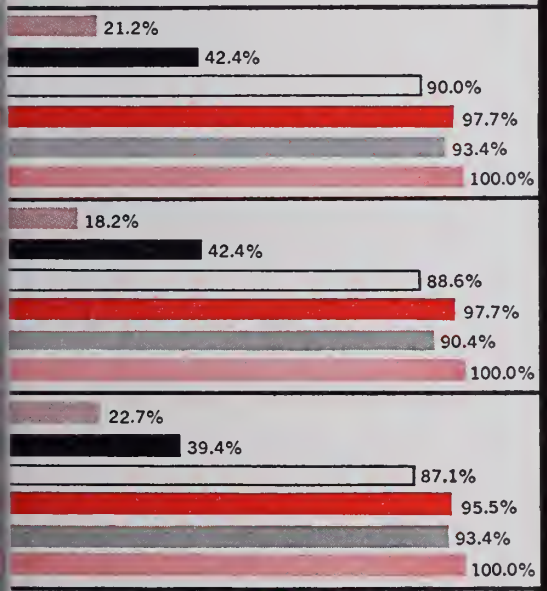


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Rapidly absorbed—stable in gastric acid,[7] TAO needs no retarding protective coating

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Highly palatable—"practically tasteless"[7] active ingredient in a pleasant cherry-flavored medium.

Dosage and Administration: Dosage varies according to the severity of the infection. **For adults,** the average dose is 250 mg. q.i.d.; to 500 mg. q.i.d. in more severe infections. **For children** 8 months to 8 years, a daily dose of approximately 30 mg./Kg. body weight in divided doses has been found effective. Since TAO is therapeutically stable in gastric acid, it may be administered without regard to meals.

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For children—flavorful, easy to administer.

Supplied: When reconstituted, 100 mg. per cc. Special calibrated droppers—5 drops (approx. 25 mg.) and 10 drops (approx. 50 mg.). 10 cc. bottle.

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To eradicate pain and physical discomfort in respiratory disorders.

Supplied: In bottles of 36 capsules.

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For dual control of Gram-positive and Gram-negative infections.

Supplied: Tablets, bottles of 60. Oral Suspension, bottles of 60 cc.

Intramuscular or Intravenous

For direct action—in clinical emergencies.

Supplied: In 10 cc. vials.

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Science for the World's Well-Being

A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

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minimal adverse reactions

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steroid effectiveness in more patients

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anti-inflammatory activity per milligram

lowest
dosage of currently used steroids

unexcelled
freedom from significant diabetogenic effects

widest
range of steroid usefulness

Schering

today's steroid...DERONIL
dexamethasone

in rheumatoid arthritis—"highly effective...in remarkably small daily milligram doses."[1]

The initial anti-inflammatory effect of DERONIL, the most active anti-rheumatic steroid on a weight basis synthesized to date,[1-4] is observed in most patients within 24 to 48 hours. Joint pain is relieved, swelling and stiffness diminish, and range of motion increases. The patient usually feels a sense of well-being and the appetite improves. The intensified anti-inflammatory activity helps assure successful initial therapy in rheumatoid arthritic cases and frequently restores relief to patients who have shown a diminution in response to previous steroids.

TYPICAL RESULTS WITH DEXAMETHASONE THERAPY IN ARTHRITIS

Investigator or Study	No. of patients	Improvement		
		Very marked or marked	Moderate	Slight or inadequate
Boland, E. W., and Headley, N. E.[1]	11	4	5	2
Bunim, J. J., and others[3]	18	5	7	6
Series A[5]	15	4	9	2
Series B[5]	6	6	—	—
Series C[5]	3	3	—	—

DERONIL IN BRONCHIAL ASTHMA AND SEVERE RESPIRATORY ALLERGIES

Investigator or Study	No. of patients	Results		
		Excellent	Fair to good	Poor
Series D[5]	24	10	9	5
Series E[5]	12	8	3	1
Series F[5]	20	13	4	3

clinically preproved in steroid-responsive diseases

IMPROVEMENT WITH DERONIL IN A WIDE VARIETY OF ALLERGIC AND INFLAMMATORY SKIN DISEASES[5]

Disease	No. of patients	Improved	Same	Worse
Seborrheic psoriasis	1	1		
Neurodermatitis	5	5		
Allergic dermatitis	5	5		
Psoriasis	5	2	1	2
Lupus erythematosus, chronic discoid	1		1	
Atopic dermatitis	3	3		
Acne rosacea	1		1	
Nummular eczema	2	2		
"id" reactions	2	2		
Contact dermatitis	2	2		
Pityriasis rosea, severe	1	1		
Urticaria, chronic	1	1		
Totals	29	24	3	2

THERAPY WITH DERONIL IN A VARIETY OF INFLAMMATORY EYE DISEASES[5]

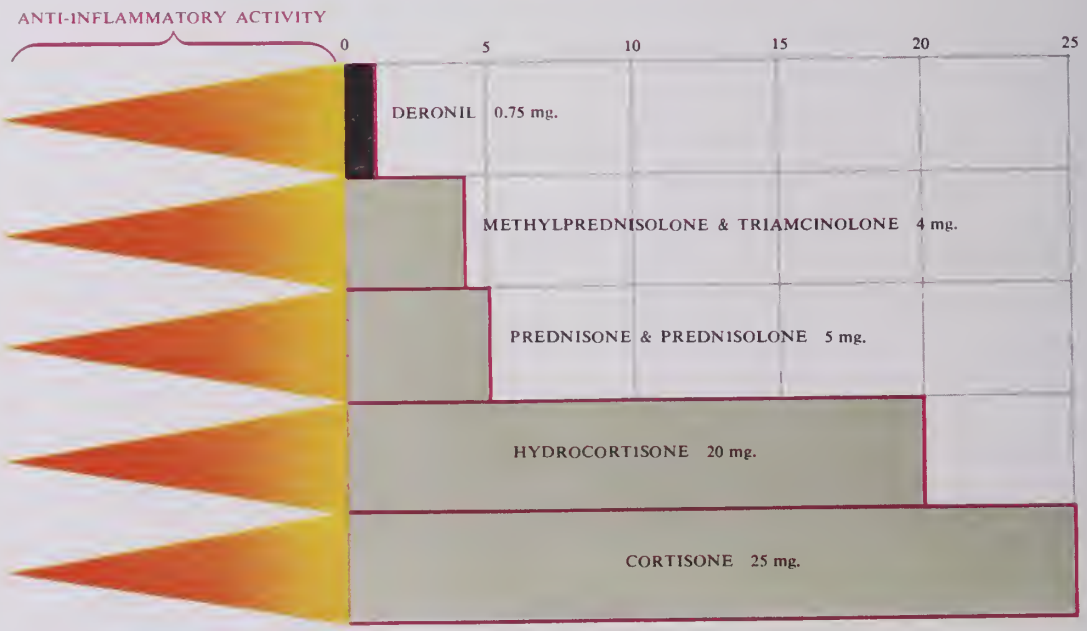
Patient, age and sex	Diagnosis	Symptoms	Results with DERONIL	Side effects
A.B., 46, M.	Postoperative uveitis		Improved; treatment being continued	None reported*
A.E., 53, M.	Choroiditis	Severe choroidal involvement	Excellent; marked improvement	None*
B.F., 60, F.	Acute choroiditis	Marked visual loss and choroidal effect	Marked improvement; therapy being continued	None*
B.K., 29, F.	Chronic uveitis	Generalized involvement	No change despite dosage increase	None*
H.K., 28, M.	Acute iritis	Blurred vision	Excellent; recovered	None*
A.P., 52, M.	Uveitis and perivasculitis	Vision loss to 20/80	Marked improvement; vision 20/30; treatment continued	None*
A.S., 34, M.	Uveitis		Excellent; patient recovered	None*

*Short-term therapy

guide to the clinical use of new DERONIL
dexamethasone

DERONIL, new 9-alpha-fluoro-16-alpha-methyl derivative of prednisolone, has at least six times the anti-inflammatory activity, milligram for milligram, of other steroids in current use. Effective dosages are the lowest in steroid therapy. And the price of DERONIL to the patient is no higher than those prevailing for other steroids.

STEROID DOSAGE EQUIVALENTS OF DERONIL



Comparative dosages of corticosteroids for equivalent anti-inflammatory activity

Dosages pre-established in the vast majority of steroid-responsive diseases

The comprehensive clinical studies conducted with DERONIL before introduction mean that initial and maintenance dosages are already established for the physician in practically all steroid-responsive diseases including rheumatoid arthritis, acute rheumatic fever, bursitis, bronchial asthma, pulmonary emphysema and fibrosis, intractable hay fever (pollenosis), disseminated lupus erythematosus, allergic and inflammatory dermatoses and eye diseases and the adrenogenital syndrome. For complete information on dosage, precautions and contraindications, consult Schering literature.

Packaging

DERONIL Tablets, 0.75 mg., scored, bottles of 50 and 500.

Bibliography

(1) Boland, E. W., and Headley, N. E.: Preliminary clinical observations with a new series of synthetic corticosteroid compounds in patients with rheumatoid arthritis, Paper presented at Annual Meet., Am. Rheumat. Assn., San Francisco, June 21, 1958. (2) Boland, E. W.: California Med. *88*:417, 1958. (3) Bunim, J. J., and others: Arthritis and Rheumatism *1*:313, 1958. (4) Spies, T. D.; Stone, R. E., and Niedermeier, W.: South. M. J. *51*:1066, 1958. (5) Reports to Clinical Research Division, Schering Corporation.

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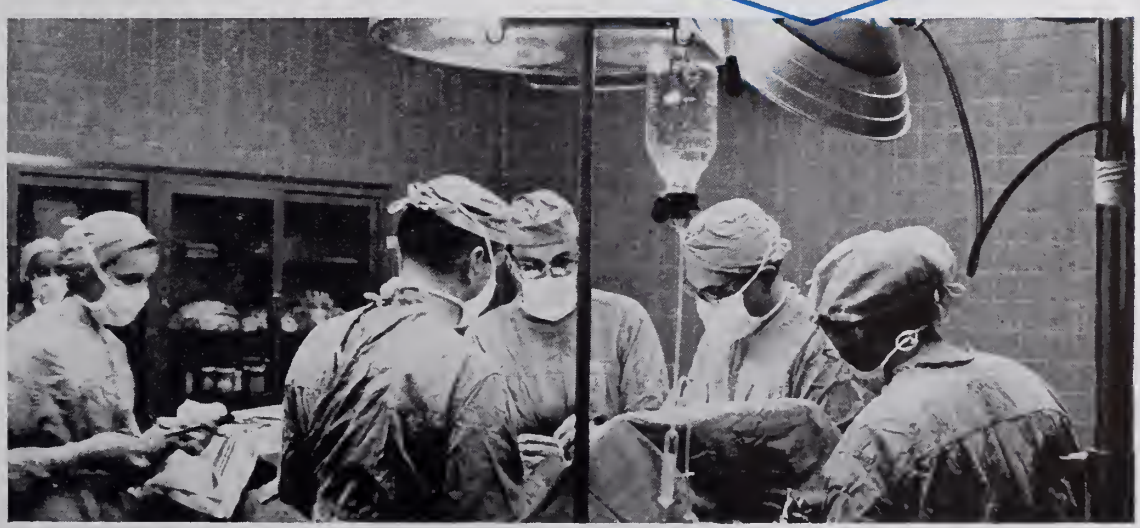
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Recommended Parenteral Dose: 25-50 mg. (1-2 cc.) I.M. q.4 h., p.r.n.

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KYNEX is extremely low in toxic potential.[2,3] Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.[2] Also minor subjective reactions are less likely to develop when the recommended dosage is used.[2]

Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first-day dose of 1 Gm. (2 tablets).

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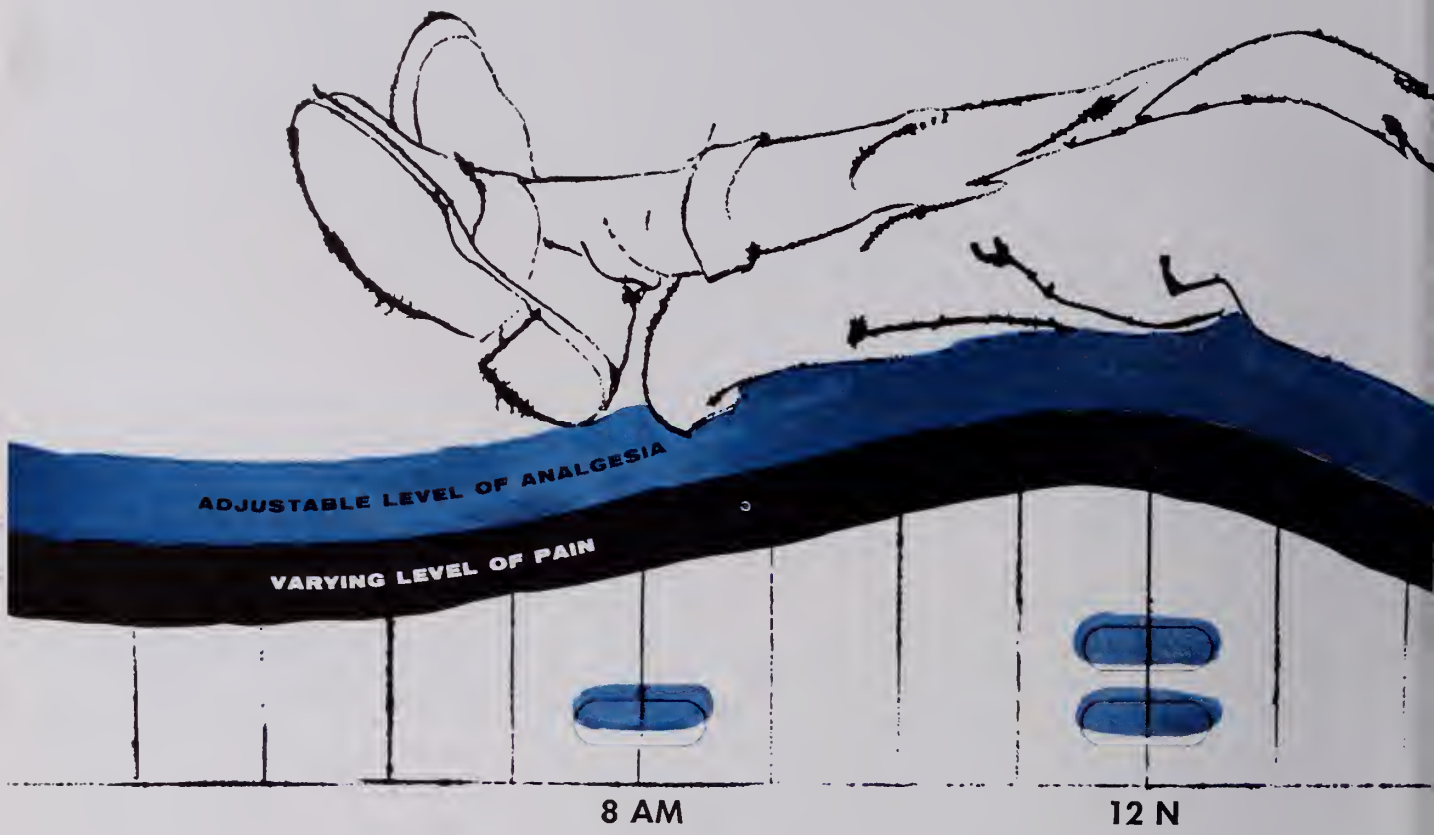
1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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- with the proper potency to match pain intensity
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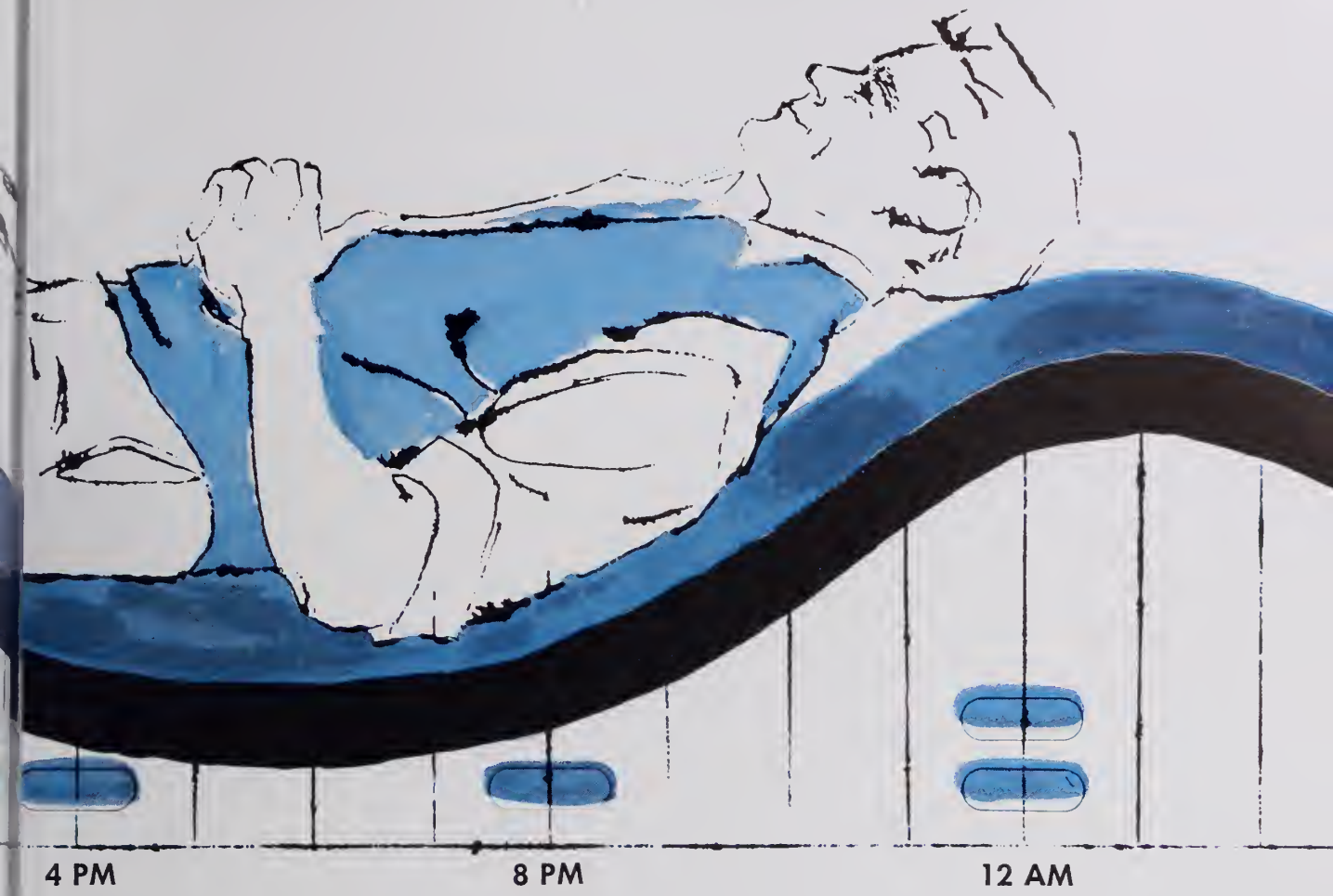
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Phenaphen and Phenaphen with Codeine provide
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Phenacetin (3 gr.) .....194.0 mg.
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For the treatment of moderately acute infections in infants and children, the recommended dosage is 1 teaspoonful per 15 to 20 lbs. of body weight per day, administered in 2 to 4 equal doses. Severe or prolonged infections require higher doses. Dosage for adults is 2 to 4 teaspoonfuls 3 or 4 times daily, depending on the type and severity of the infection.

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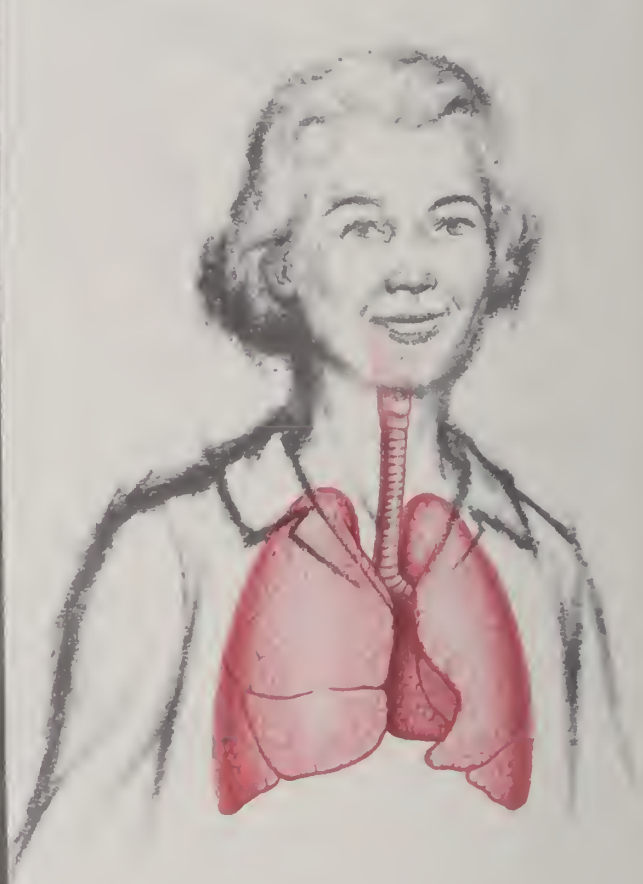
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Secobarbital (Warning: May be habit-forming)	20 mg.
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CLINICAL BRIEFS FOR MODERN PRACTICE

Is there a relationship between premature impotence and diabetes?

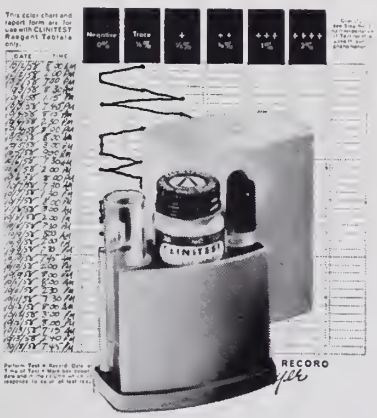
Yes. The incidence of premature impotence was studied in 198 diabetic men,[1] and found to be two to five times higher than that reported for the general population.[2] In many of the cases observed, impotence developed early in the history of the disease, suggesting that the possibility of diabetes mellitus be considered whenever a man complains of premature impotence.

(1) Rubin, A., and Babbott, D.: J.A.M.A. *168*:498, (Oct. 4) 1958. (2) Kinsey, A. C.; Pomeroy, W. B., and Martin, C. E.: Sexual Behavior in the Human Male, Philadelphia, W. B. Saunders Company, 1948.

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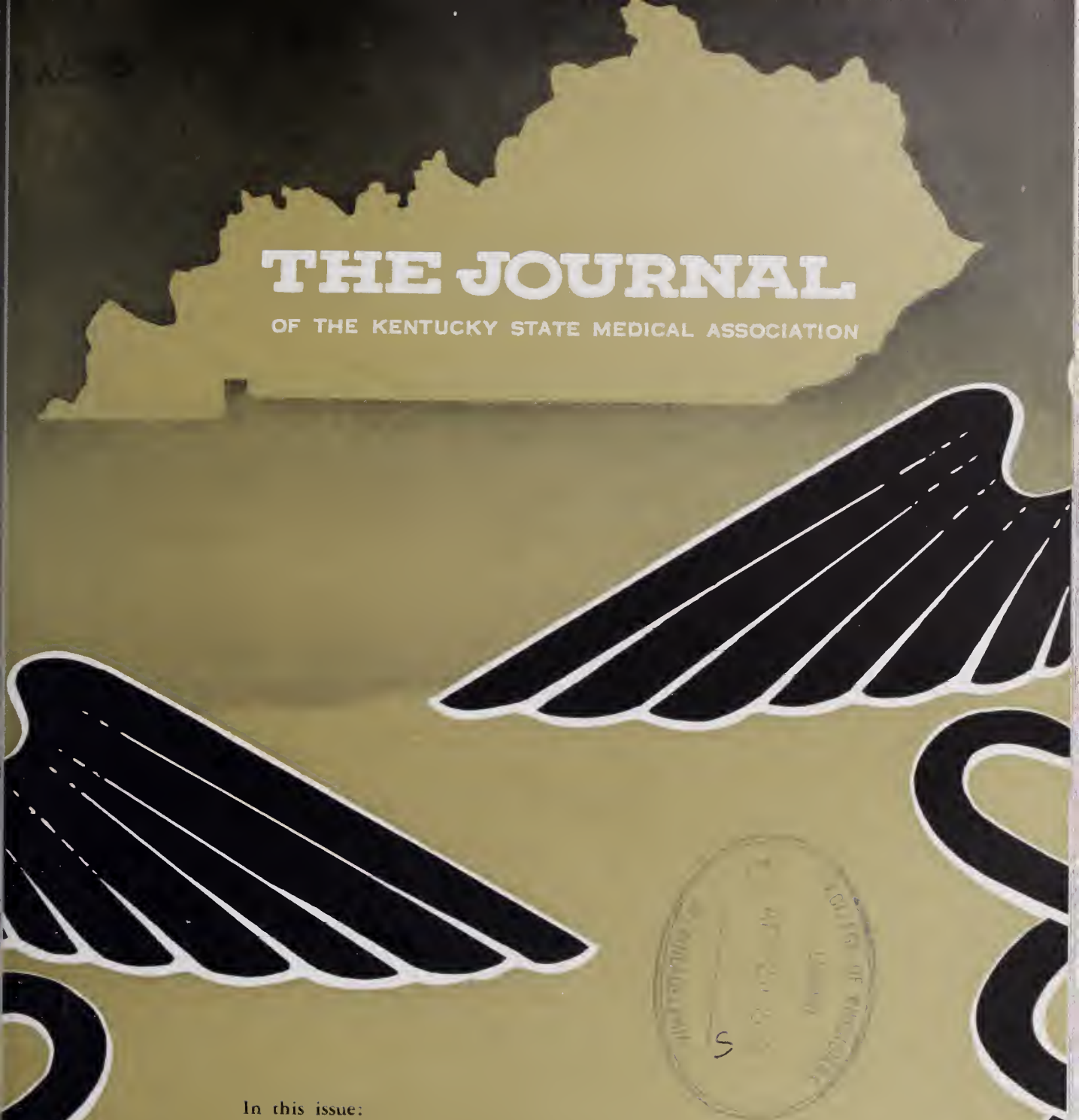
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WIDE-SPECTRUM ANTIMICROBIAL EFFECTIVENESS

CHLOROMYCETIN SUCCINATE, providing broad-spectrum antimicrobial effectiveness, may be used whenever CHLOROMYCETIN is indicated. It has produced effective response in respiratory, gastrointestinal, and rickettsial infections.[3-5] Because of the rapid, effective blood levels of CHLOROMYCETIN provided, it is especially useful in *Hemophilus influenzae* meningitis, in certain septicemias, typhoid fever, and other *Salmonella* infections.[3,5]

TYPICAL CLINICAL EXPERIENCE WITH CHLOROMYCETIN SUCCINATE

Type of infection	Number of Patients	RESULTS Excellent to Good	Fair	Poor
Respiratory[3,4]*	32	32		
Shigella dysentery[2]	14	14		
Enteritis[3]	10	6	2	2
Bacteremia[3,5]	5	5		
Meningitis[3,5]	4	3		1**
Rocky Mountain spotted fever[3,5]	2	2		
Ear abscess with cellulitis[4]	1	1		
Lung abscess[4]	1			1
Typhoid fever[5]	1	1		
TOTALS	70	64	2	4

*Includes 15 patients who were administered CHLOROMYCETIN SUCCINATE by nebulization under intermittent positive pressure breathing.

**Patient was hydrocephalic at birth; cerebrospinal fluid was sterile at time of death.

WELL TOLERATED

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DOSAGE AND ADMINISTRATION—*Adults:* 1 Gm. every six to eight hours. *Children:* 100 mg. per Kg. of body weight per day in divided doses at six- to eight-hour intervals. The total dose in children should not exceed the adult dose of 1 Gm. given at any single injection, with exception of treatment of *Hemophilus influenzae* meningitis in which higher doses are employed.

In all cases, severity of infection and clinical response to therapy should be the guiding factors determining the proper dosage schedule. Premature and full-term newborn infants require special dosage supervision. For details see literature.

SUPPLY—CHLOROMYCETIN SUCCINATE (chloramphenicol sodium succinate, Parke-Davis) is supplied in Steri-Vials,® each containing the equivalent of 1 Gm. chloramphenicol; packages of 10.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately, or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES—(1) Glazko, A. J., *et al.*, in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 792. (2) Unpublished data: Research Laboratories, Parke, Davis & Company, 1958. (3) Ross, S.; Puig, J. R., & Zaremba, E. A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 803. (4) Payne, H. M., & Hackney, R. L., Jr.: *ibid.*, p. 821. (5) McCrumb, F. R., Jr.; Snyder, M. J., & Hicken, W. J.: *ibid.*, p. 837.

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President's Page*



Dr. Meredith
Vice President—Eastern

The problem of "physician distribution" in Kentucky is becoming more acute every year. Physicians in the rural areas of Kentucky are dying and retiring, and they are not being replaced in a large enough number.

The ten large urban areas, or counties, have less than one-third of the population, and they now have two-thirds of the physicians. The one hundred and ten rural counties have two-thirds of the population and one-third of the active practicing physicians. To be more specific, forty-six counties in Kentucky have five or less physicians.

According to the Physicians Register, since the 1953 graduation ninety-six physicians have settled in the urban areas and only forty-eight physicians in the other one hundred and ten counties. This trend has become more apparent and more alarming in the last fifteen years.

The new medical school to open at the University of Kentucky should be a great help in supplying more physicians. The University of Louisville has been the supplier of "the life blood" of physicians for Kentucky for many years and it will continue to do so.

The Rural Kentucky Medical Scholarship Fund has made a commendable start at meeting this problem. It has helped or is helping a total of 166 medical students. Forty-eight of these are now practicing in rural Kentucky areas, 12 are in the armed forces, and 79 are either in medical school or serving internships. Others have exceeded their moral obligation and before moving from a rural area have in most cases served double the time called for under the Plan. Obviously, this program is already a positive force in providing medical care for rural Kentuckians, and it is felt that it will be increasingly effective in the future.

But the fact remains that the young physicians are still showing preference to the cities at a two to one ratio.

There are many excellent professional and financial opportunities in these rural areas. Why can't we promote them?

These opportunities are becoming more and more attractive. There are better roads, more and better hospitals, better schools, larger payrolls from new industries, and more attractive social and recreational facilities.

What can we do to promote these opportunities? What can we do to reverse this trend "to the cities" so that all of our people will have better medical care, and we can cut off at the "grass roots" many of the complaints about our medical profession.

Let's give this *ailment* our immediate attention and find a *cure*.

I wish to take this opportunity to thank the House of Delegates for the honor bestowed upon me, a country doctor, as I feel that they were also honoring more than 800 other country doctors.

T. O. Meredith, M.D.
Vice President—Eastern

**This is the second of a series of three guest articles written by the KSMA vice presidents at the invitation of Robert W. Robertson, M.D., president.*



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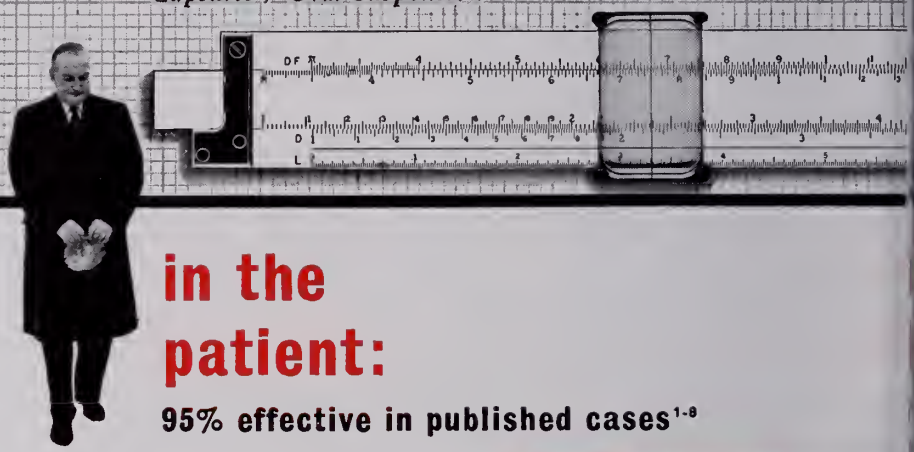
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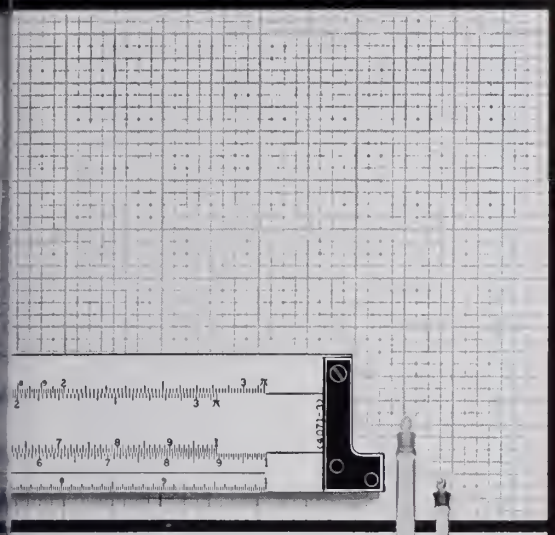
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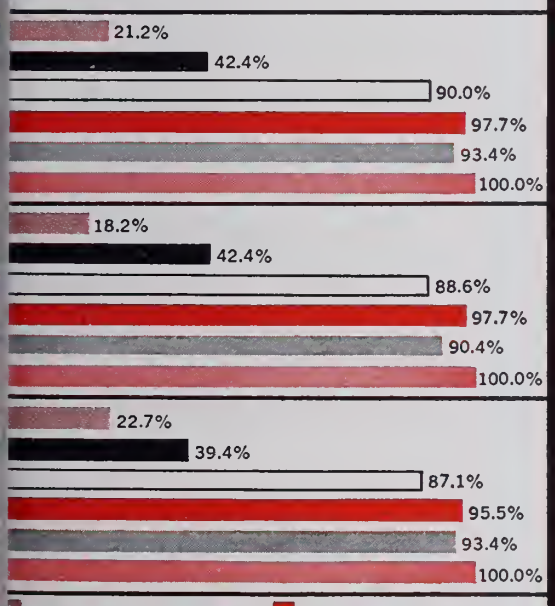
Conditions treated	No. of Patients	Cured	Improved	Failure
ALL INFECTIONS	**558**	**448**	**80**	**30**
Respiratory infections	**258**	**208**	**31**	**19**
Pharyngitis and/or tonsillitis	65	58	5	2
Pneumonia	90	66	17	7
Infectious asthma	44	38	—	6
Otitis media	31	29	2	—
Other respiratory (bronchitis, bronchiolitis, bronchiectasis, pneumonitis, laryngotracheitis, strep throat)	28	17	7	4
Skin and soft tissue infections	**230**	**191**	**38**	**1**
Infected wounds, incisions and lacerations	41	33	8	—
Abscesses	51	43	8	—
Furunculosis	58	51	6	1
Acne, pustular	43	28	15	—
Pyoderma	19	19	—	—
Other skin and soft tissue (infected burns, cellulitis, impetigo, ulcers, others)	18	17	1	—
Genitourinary infections	**28**	**19**	**3**	**6**
Acute pyelitis and cystitis	10	8	2	—
Urethritis with gonorrhea or cystitis	8	8	—	—
Pyelonephritis	4	1	—	3
Salpingitis	5	1	1	3
Pelvic inflammation with endometriosis	1	1	—	—
Miscellaneous (adenitis, enteritis, enterocolitis, subacute bacterial endocarditis, fever, hematoma, staphylococcus carriers, osteomyelitis, tenosynovitis, septic arthritis, acute bursitis, periarthritis)	**42**	**30**	**8**	**4**



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References: 1. Koch, R., and Asay, L. D.: J. Pediat., in press. 2. Leming, B. H., Jr., et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 3. Mellman, et al.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 4. Olansky, S., and McCormick, G. E., Jr.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 5. Shubin, H., et al.: Antibiotics Annual 1957-1958, New York, N. Y., Medical Encyclopedia, Inc., 1958, p. 679. 6. Isenberg, H., and Karelitz, S.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 7. Wennersten, J. R.: Antibiotic Med. & Clin. Therapy 5:527 (Aug.) 1958. 8. Kaplan, M. A., and Goldin, M.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958. 9. Truant, J. P.: Paper presented at the Symposium on Antibiotics, Washington, D. C., Oct. 15-17, 1958.

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IN THE BOOKS



LOVE, SKILL AND MYSTERY—A Handbook to Marriage: by Theodor Bovet; published by Doubleday and Company, Garden City, N. Y.; 188 pages; price, $3.50.

This book, suitably subtitled "A Handbook of Marriage," is written by a Swiss physician who has had a broad experience in marriage counseling. Apparently it has been quite popular in England and on the continent. Throughout the author emphasizes that marriage involves more than sex or love, that it has a spiritual basis as well. One is impressed with the writer's experience, his integrity and sincerity in trying to underline the religious aspects of marriage.

The format is attractive and the book is well organized. The sections are short, detailed, well-written and do not suffer from the lack of cohesion so frequent in many translations. There is wide coverage of the various aspects of sexual adjustment, etc. with valuable discussions on love and marriage, men and women, the fellowship of love (including techniques), "art of love," the fruits of marriage, obstacles and crises in ....., etc.

Basic psychological concepts of personality development are integrated into the whole of the book and many of the psychopathological pitfalls are briefly discussed. Practical suggestions are made where appropriate. An effort has been made to reconcile some of the theological differences in the Roman Catholic and Protestant attitudes toward marriage, divorce, birth control, etc. My only objection was the rather arbitrary dismissal of psychoses as being hereditary in nature and relatively untreatable with the vague inference that they should be "bred out." This was, however, a rather minor point and does not mar the value of the book as a whole.

This book would be quite useful for anyone requesting a marriage manual. Its outstanding characteristics are its completeness, its clarity and its emphasis on the need for something spiritual in a successful marriage. It might also be valuable for young people contemplating marriage, as well as those struggling through some of its crises. Very few people would read this without reflection and many might gain some better understanding of themselves or their mates.

John P. Bell, M.D.

IDEALS IN MEDICINE: edited by Vincent Edmunds, M.D., and G. Gordon Scorer, M.D.; published by the Christian Medical Society, Chicago; 1958; 191 pages; price, $3.

This book of twenty-four chapters and one-hundred and eighty-seven pages is a well-written, up-to-date treatment of the subject of medical ethics and in particular, the approach of the Christian doctor to the subject.

Although this is a topic that is often discussed, there is actually very little written for the younger doctor or student to refer to other than the spoken advice of the older colleagues.

Since the authoring of the Hippocratic Oath in 460 BC, there has been a tremendous advance in the methods of and the problems of medical practice. There has, during this time, been little change in what we refer to as medical ethics. The basic problems of the practicing physician, relative to his relationship with his patients and fellow practitioners, has not changed, but in the complexity of modern society, one is likely to welcome a book which offers help in approaching and handling them from a Christian point of view.

The authors in no way attempt to set double standards for the Christian and non-Christian physician. They attempt in no way to say or infer that the Christian is more honest, more moral, less sympathetic, or less conscientious. They do say "That none can love like Christ, except Christ be in him."

The discussions of the subjects of Sexual Problems, Abortions, Eugenics, and Euthanasia are discussed sensibly and with feeling. The management of incurable disease, use of new drugs, and the importance of professional secrecy are dealt with in a practical and realistic manner.

The chapter on Ultimate Loyalties can be summed up by saying that medical duty is too often discussed only in terms of the profession, or the hospital, or the state. The Christian doctor may not be outstanding in the natural ability or in technical skills. He can at least, aim to exceed in love for his neighbor—in thoughtfulness and self sacrificing attention to his welfare.

The late Lord Lister paraphrased the Golden Rule to say, "The one rule of pratcice is to put yourself in the patient's place."

I recommend this book as worthwhile reading.

Donald Chatham, M.D.

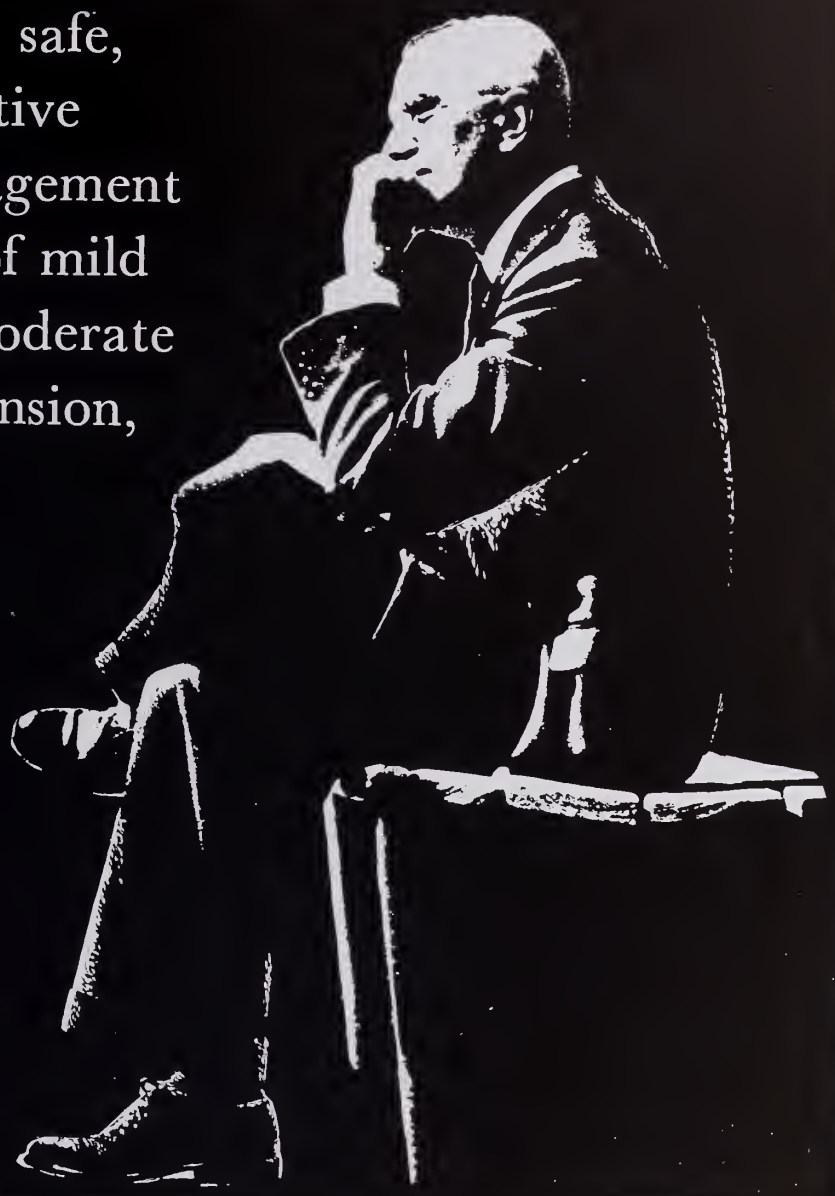
THE BIRTH OF NORMAL BABIES: by Lyon P. Strean, Ph.D., D.D.S., FAPHA, published by Twayne Publishers, Inc., December, 1958; price, $3.95.

The author points out in this book that traumatic, physiologic and emotional stress will lead to miscarriage, stillbirth or congenital anomalies in the baby. He believes that these stresses cause the secretion of excessive amounts of cortisone which in turn interferes with normal developing processes in the fetus during the early weeks of pregnancy.

Strean cites a study (retrospective) on patients whose infants had cleft palate. Of 228 patients in this series, there were 4 sets of identical twins. Only one twin in each set had cleft palate. These twins had the same genetic background and both were

(Continued on page 394)

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IN THE BOOKS

(Continued from page 392)

exposed to the same stress and the same amount of cortisone. Yet only one developed cleft palate. This makes it difficult for me to accept the theory as a cause of congenital anomalies.

One chapter is devoted to Precautionary Measures and gives Ten Commandments as a guide to radiant and blessed motherhood. These are all good basic principles for the expectant patient. Advising the patient, however, to have childhood diseases in childhood is a little hard for her to carry out.

Dr. Strean's book is intended to give comfort to pregnant women by pointing out how they can have normal babies. To me, it creates just the opposite reaction. He states that certain congenital defects when not due to heredity must be due to some stress the patient brings on herself. This, it seems to me, would tend to make many patients feel guilty when miscarriage takes place or the baby has a congenital anomaly, when really the circumstances were not due to anything the patient did or did not do.

Doctor Strean leaves no place for an abnormal development of fetal tissues. The trouble either must be heredity (bad genes) or stress. This I also challenge somewhat. I feel that even in ideal circumstances of heredity and the absence of stress that an occasional abnormal fetus will occur. From the standpoint of a practicing obstetrician, this is more consoling to the patient than to say her miscarriage or abnormal child is due to heredity or to something she did.

Glenn W. Bryant, M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

THE ANATOMY OF THE NERVOUS SYSTEM: by Stephen Walter Ranson, M.D., and Sam Lillard Clark, M.D., published by W. B. Saunders Company, Philadelphia and London.

CURRENT THERAPY—1959: edited by Howard F. Conn, M.D., published by W. B. Saunders Company, Philadelphia and London.

CHILDBEARING BEFORE AND AFTER 35: by Adrien Bleyer, M.D.; published by the Vantage Press, New York.

DISEASES OF THE COLON AND ANORECTUM: by Robert Turell, M.D., volumes 1 and 2; published by W. B. Saunders Company, Philadelphia and London.

TEXTBOOK OF SURGERY: edited by H. Fred Moseley, M. A., D. M., published by C. V. Mosby Company, St. Louis.

THERAPEUTIC RADIOLOGY: William T. Moss, M.D., published by C. V. Mosby Company, St. Louis.

THE PLASMA PROTEINS: Paul G. Weil, M.D., published by J. P. Lippincott Company, Philadelphia and Montreal.

MATERNITY: A Guide to Porspective Motherhood: by Frederick W. Goodrich, Jr., M.D., published by Prentice-Hall, Inc., Englewood Cliffs, N. J.



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PUBLIC HEALTH PAGE

The Physician And The School-Age Child

RUSSELL E. TEAGUE, M.D.

Commissioner of Health, Commonwealth of Kentucky

School health services are the joint responsibilities of the school, the health department, and the community. Private physicians carry the primary responsibility for furnishing medical care to the community, and therefore represent an important part of the school health services. Health services originated to control the spread of contagious and nuisance disease, but which the declining importance of these diseases the major emphasis today is placed upon discovery of physical defects and the correction of the remedial defects found. The ultimate goal of school health service is to maintain, protect, and promote optimal physical, mental, emotional, and social health of the school-age child. Such a goal requires continuous health supervision which can only be met through a partnership in the fields of education and medicine.

Often when routine examinations are required, so much time is spent in securing the examinations that little time is left to follow through on the defects found. A more effective use of time would be to concentrate on defects that have been discovered. As the physician needs information regarding the behavior of the child before referral, the teacher needs recommendations by the physician that concern the child at school. The family physician who examines or treats the child of school age has a responsibility to the school to interpret information about the child that will aid improvement in his health and assist him in making a satisfactory school adjustment. Some defects can be corrected; however, other disabilities may require educational or physical adjustment.

Limiting the frequency of school examinations does not mean that school age children do not need regular examinations. Actually, it means that frequent examinations should be the responsibility of the parent, and the private physician, not the school. Such a plan for health examinations has shown to be effective, less wasteful, and enables the school, the health department, the physician, and the community to concentrate on the more important health problems and on securing adequate care for the children who need it.

It is generally agreed that all children should be examined prior to entrance to school, preferably by their family physician. This examination allows the detection of physical defects which may be corrected and for the completion of immunizations needed before the child enters school. Such an examination offers opportunity to discuss with parents the health status, health habits, or emotional problems of the child.

The frequency with which examinations should be repeated is a debatable question and should be determined locally according to the available medical manpower. The number of required examinations may vary from one at entrance to school to annual examinations. Fewer examinations of good quality are preferable to frequent attempted coverage of the school with inadequate examinations that are medically and educationally unsound. Mass examinations tend to be done hurriedly and give parents and children a false sense of security. Subsequent examinations are desirable at the pre-adolescent age, or upon entering junior high school, and at the senior high school level prior to graduation. However, routine periodic examinations are difficult to provide with a shortage of medical personnel which exists in many areas of Kentucky, so a selective method of finding those children who need special examinations is necessary.

Studies by Yankauer* and others suggest that periodic school medical examinations disclose few previously unknown health problems. The authors therefore recommend that examinations be limited to one thorough check-up at school entrance with subsequent examinations only on a referral basis. Referral examinations are those used to check suspected deviations from normal health. All screening tests, teacher observations, nurse judgments, and other procedures which suggest the presence of health problems should lead to such referral examinations. A summary of screening tests and observations should be available to the physician.

While the medical examination is best done in the physician's office, screening tests for vision and hearing are best done in the school while children are in groups. Visual acuity in children changes rapidly; therefore, visual screening should be done annually. As a result of middle ear infection or blockage of the eustachian tube by lymphoid tissue, deafness is not uncommon in the school-age child and hearing tests are recommended every two years.

(Continued on page 496)



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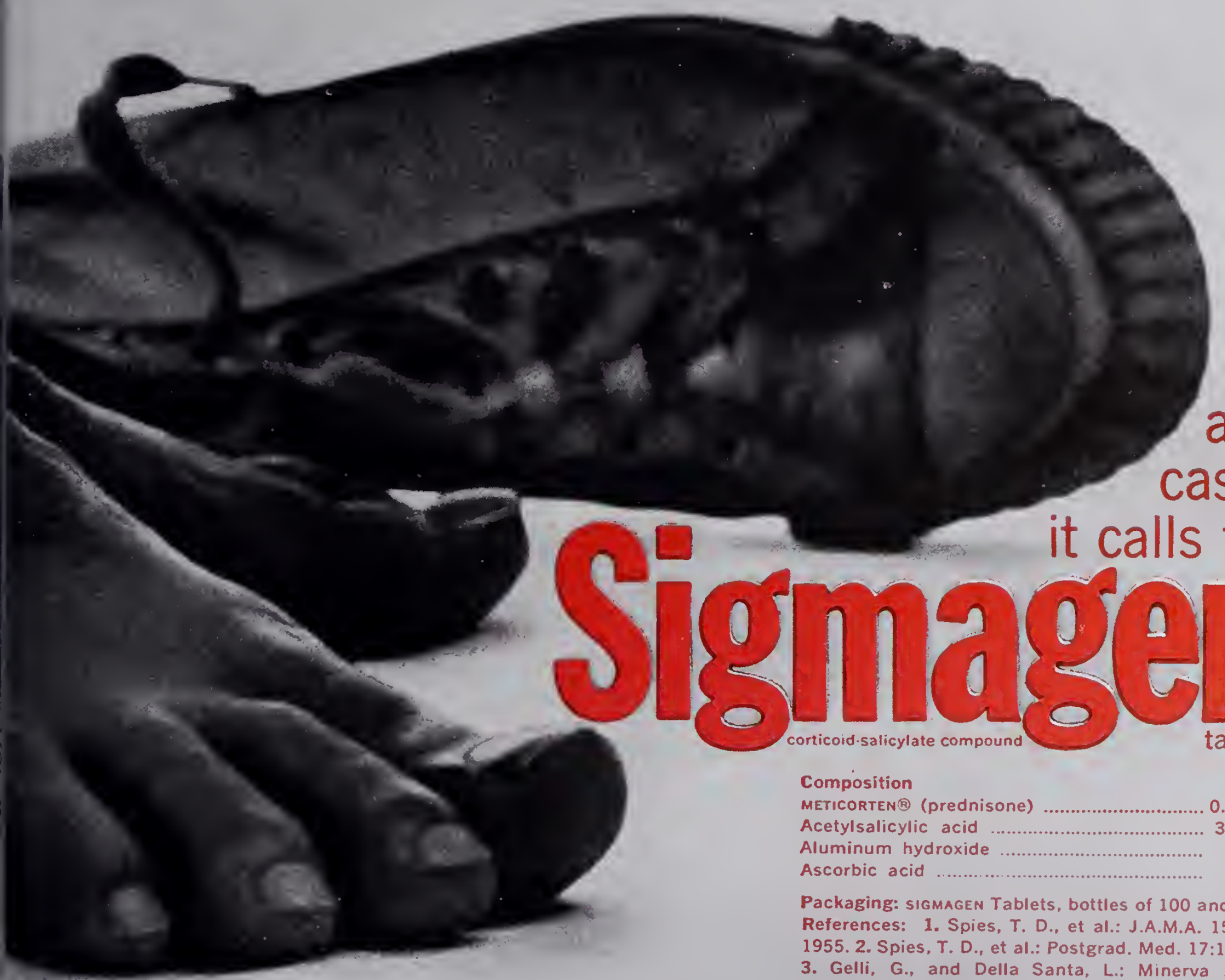
. much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

THERAPY SHOULD BE INDIVIDUALIZED

acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



in any case it calls for

Sigmagen®

corticoid-salicylate compound tablets

Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SG-J-618

Convenient information for physicians starting diabetic patients on

DIABINESE

simple once-a-day dosage in practice

During the initial control period, the patient should check his urine at frequent intervals, and report at least once weekly for review of symptoms, physical examination, urine and/or blood examination for glucose.

The New Patient *(no previous antidiabetic therapy)*

1. Initial daily dose 500 mg. (2 tablets of 250 mg. each) with breakfast.

2. In elderly patients, initial dose 250 mg. (1 tablet) daily.

3. CONTROL PERIOD

(a) If blood sugar reaches normal levels after three to seven days, or if glycosuria disappears, lower daily dose of 500 mg. to a level between 250 mg. (1 tablet) and 375 mg. (1½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage may be reduced to as low as 100 mg.

(b) If hyperglycemia or glycosuria persists or develops, increase the daily dose from 500 mg. to 625 mg. (2½ tablets of 250 mg.) with breakfast daily. In elderly patients, dosage should be increased from 250 mg. according to patient response.

(c) Continue weekly adjustments during first month of therapy until maintenance dose has been established. Adjustments below 250 mg. daily are best made in steps of 100 mg. (one 100 mg. tablet). The maintenance dose may occasionally be as low as 100 mg. (one 100 mg. tablet daily) or, rarely, as high as 1.0 Gm. (four 250 mg. tablets) daily. Do not exceed daily dose of 1.0 Gm.

Transfer of Patient from Insulin

1. If patient is taking 40 or less units of insulin daily and gives no history of severe or "brittle" diabetic response, discontinue insulin and replace with DIABINESE as in The New Patient.

2. Complete control period as for The New Patient. Priming ("loading") doses should not be used.

3. If patient is taking more than 40 units of insulin daily, or shows evidence of severe or brittle diabetes, reduce insulin dose by 50 per cent and initiate DIABINESE therapy as for The New Patient. Further reduction of insulin dosage depends on patient response.

Transfer of Patient from Other Oral Medication

Where less than satisfactory control has been achieved with other oral medication, or where a change to once-a-day dosage is desired, DIABINESE may be successfully substituted. Such a transfer may be made by discontinuing previous oral medication, substituting DIABINESE, and continuing control period as for The New Patient. Avoid priming doses.

The clinical safety of DIABINESE has been established by more than two years' trial. By adherence to the above dosage schedule, side effects of DIABINESE will generally be infrequent, mild, and transient.

Pfizer

DIABINESE®

brand of chlorpropamide

once-a-day dosage

THE MOST EFFECTIVE ORAL ANTIDIABETIC AVAILABLE

SUPPLIED: *Tablets,* 250 mg., bottles of 60 and 250, white, scored. 100 mg., bottles of 100, white, scored.

Science for the world's well-being Pfizer PFIZER LABORATORIES Division, Chas. Pfizer & Co., Inc. Brooklyn 6, N. Y.

Proven

in over three years of clinical use
in over 600 clinical studies

Specific

FOR RELIEF OF ANXIETY
AND MUSCLE TENSION

Selective

Does not interfere with autonomic function
Does not impair mental efficiency,
motor control, or normal behavior
Has not produced hypotension,
agranulocytosis or jaundice

MEPROBAMATE (WALLACE)

Miltown®

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.

WALLACE LABORATORIES, New Brunswick, N. J.

THE HEART DISEASE PATIENT NEEDS RELIEF FROM EMOTIONAL STRESS



ANXIETY INTENSIFIES the physical disorder in heart disease. "The prognosis depends largely on the ability of the physician to control the anxiety factor, as well as the somatic disease."

(Friedlander, H. S.: The role of ataraxics in cardiology. Am. J. Cardiol. 1:395, March 1958.)

TRANQUILIZATION WITH MILTOWN enhances recovery from acute cardiac episodes and makes patients more amenable to necessary limitations of activities.

(Waldman, S. and Pelner, L.: Management of anxiety associated with heart disease. Am. Pract. & Digest Treat. 8:1075, July 1957.)

Miltown®

meprobamate (Wallace)

Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). In combination with a nitrate, for angina pectoris: MILTRATE* (Miltown 200 mg. + PETN 10 mg.).

Miltown causes no adverse effects on heart rate, blood pressure, respiration or other autonomic functions.

*TRADE-MARK CM-8275

WALLACE LABORATORIES, *New Brunswick, N. J.*

UNIQUE VITAMIN SUPPLEMENT

NEW VIGRAN CHEWABLES

SQUIBB MULTIPLE VITAMIN SOFT TABLETS

fruit-punch flavored tablets that will actually "melt in the mouth"



can be chewed like candy



can be crushed and sprinkled on cereal or other food



can be dissolved in water, juice or milk



can be sucked and will dissolve like a lozenge



can be easily swallowed (small tablet size)

VIGRAN CHEWABLES *taste like candy*, but contain *no ingredients harmful to teeth.* Important, too, is that VIGRAN CHEWABLES *dissolve easily* in the mouth and *smell good.* These advantages will also appeal to your elderly patients. And VIGRAN CHEWABLES provide at least 125% of the minimum daily requirements for vitamins A, D, B_1, B_2, niacinamide and C, and significant amounts of other essential vitamins.

Each VIGRAN CHEWABLE tablet contains:

Vitamin A	5,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin C	75 mg.
Vitamin B_1	3 mg.
Vitamin B_2	3 mg.
Vitamin B_6	2 mg.
Niacinamide	25 mg.
Calcium Pantothenate	3 mg.
Vitamin B_{12}	5 mcg.

Available in Rx-size bottles of 30 and 90.

SQUIBB

Squibb Quality—the Priceless Ingredient

'Vigran'® is a Squibb trademark

From the Files of the

Committee for the Study of Maternal Mortality

Case #16:

The patient was a 30-year-old colored married gv 7, para 6 who was treated by a private physician. It was not stated as to when she was seen initially nor were any facts given regarding the number of prenatal visits or findings.

The physician who answered the questionnaire delivered the patient since her physician was not available.

She was admitted to the hospital at 10:45 P.M., July 6, 1957 apparently at term, in active labor. The L M P was not given, her blood pressure was normal 130/80. She was taken to the delivery room at 11:15 P.M., and delivered spontaneously at 11:35 P.M. a 6 lb. 12 oz. girl. "After one hour of attempting to deliver the placenta and control the hemorrhage the vagina was packed and the patient sent to the ward with orders to watch carefully and give ergotrate if the patient should hemorrhage." When the doctor who delivered the patient left she was described as "in good contion with no evidence of shock." About 5 hours later the patient became irrational and was seen by her physician. He ordered fluids and sedation. There was no mention of blood pressure or pulse. The patient died at 6.45 A.M., seven hours after delivery.

An autopsy was done and findings were:

1) Postpartum state after recent term delivery
2) Retained placenta
3) Uterine hemorrhage due to retained placenta
4) Pulmonary edema right lung
5) Fibrous pleural adhesions, right

Comment

This case is presented purposely for several reasons. The lack of details supplied by the attending physician made intelligent study of this case difficult. The committee can, however, now report better cooperation. This year the questionnaires have been returned more promptly and more completely answered.

Even with the paucity of information supplied it was apparent this case was improperly managed. If the patient isn't anesthetized and is not bleeding the doctor may wait for the placenta to separate spontaneously *as long as he remains in attendance*. There is no justification for ever returning a delivered woman to her room with the placenta undelivered.

Every intern should know how to manually remove the placenta and how the empty gravid uterus feels when it is then explored. Should he then encounter an adherent placenta he will know how to develop a cleavage plane without fear of rupturing the uterus. If this was a placenta accreta, we would expect difficulty in developing a plane of separation, but under those circumstances the patient should not merely have had the vagina packed and watched. Actually such a condition is quite rare and diagnosis can correctly be made only microscopically. There was no evidence that this was present in this case.

We were told simply that five hours postpartum the patient became irrational and was seen by her physician. There was no mention of her blood pressure or of the placenta being separated, merely that he ordered fluids and sedation. She died two hours later without any apparent attempt to control the bleeding or replace blood loss. This patient was in a hospital where good consultation was available if requested. It may well have been that her physician was not informed of her progressive down hill course; if so part of the responsibility would be with hospital personnel. In any event the committee felt this was a direct obstetric death preventable by the physician.

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with low incidence of sensitivity reactions . . .
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Sulfamethoxypyridazine Lederle
0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
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RESEARCH
EDUCATION
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AMERICAN CANCER SOCIETY

SPONTIN IN SERIOUS

A Special Report from Abbott
to the Medical Profession
on a Year's Clinical Experience
with SPONTIN®
(Ristocetin, Abbott)

In a Spanish province, a patient lay dying of endocarditis. A short wave radio appeal for SPONTIN was intercepted by a Baltimore physician. The antibiotic was immediately flown to this faraway land, and 10 days later—the patient had recovered.

In Chicago, a moribund patient had been administered 18 combinations of 10 different antibiotics without success. Involved was a hospital-acquired staphylococcal pneumonia—plus complications. SPONTIN was substituted and the patient lived.

A five-week-old infant was critically ill with staphylococcal enteritis. Treatment failures included erythromycin and chloramphenicol. Three days of SPONTIN saved this life. The list is long and impressive and it grows daily.

Recently, a study[1] was made of serious and resistant staphylococcal infections reported to Abbott Laboratories. Many of these cases had serious complicating diseases—many were moribund, or almost so, at the time SPONTIN was started. Yet, out of the 160 staphylococcal cases studied, 93 were reported cured and 38 improved after the administration of SPONTIN.

Out of the total of 251 patients with severe infections caused by gram-positive or mixed organisms, 149 were reported cured and 53 others improved. And the record for pediatric practice was every bit as good.

Additionally, SPONTIN continues to exhibit exceptional bactericidal activity against coccal infections[2]. And, according to another study, SPONTIN provides successful short-term therapy in endocarditis[3].

Only last October, at the Antibiotics Symposium in Washington, D. C., a panel of six leading antibiotic experts placed SPONTIN at the top of all other commercially-available antibiotics for treating serious staphylococcal infections. Also, six papers—all dealing with the effectiveness of ristocetin (SPONTIN®) in treating staphylococcal infections—were presented at the Symposium.

One of the most encouraging aspects of the year's literature on SPONTIN is the increasing testimony to its safety. As the months have passed and cases have accumulated by the hundreds, it has become apparent that careful attention to dosage recommendations has practically eliminated toxicity and side effects as serious obstacles to therapy. Also, recent improvements have been made in the manufacture of SPONTIN; the drug is now made from pure crystals.

A recent report[4] in the Journal of the American Medical Association concluded, "It is our opinion that, if proper precautions are observed, ristocetin is a [well tolerated] and potent agent to employ in the treatment of staphylococcal infections." And in another study, after successfully treating 28 patients with a variety of staphylococcal infections, the authors reported[5], "No serious complications were noted."

Few more dramatic records have been written in such a short space of time. SPONTIN has proved itself to be a good answer, perhaps the best answer at present, to the resistant staphylococcal problem – and of real value in other serious coccal infections. It may well be your answer when you're confronted with a serious infection.

Abbott

901066

STAPHYLOCOCCAL INFECTIONS

Excerpts from Reports Read at the Antibiotics Symposium

Spontin In Treating Severe Respiratory Infections —"In 13 of 20 patients the results were excellent, with clinical response being evident within one to four days after institution of therapy. In three additional patients, there was some degree of improvement in pneumonic processes superimposed on tuberculosis in two cases and on pulmonary neoplasm in one. In all other cases, serious antecedent pathology undoubtedly influenced the negative or equivocal response to ristocetin therapy.[6]"

Spontin In Treating Staphylococcal Infections—After successfully treating 28 patients, the authors wrote, "Ristocetin or Spontin has proved to be bactericidal and bacteriostatic, particularly for the *Staphylococcus aureus,* which is often resistant to many other antibiotics.[5]"

Spontin In Treating Seven Difficult Cases — "Ristocetin has produced excellent results in eradicating, mitigating or preventing infection in seven selected difficult cases. Six of the seven cases involved *Staphylococcus aureus* which did not respond to chemotherapy with other antibiotics.[7]"

Spontin Blood Levels In Children — "Ristocetin was administered as a single intravenous injection of 12.5 milligrams per kilogram. This resulted in serum levels ranging from 1.3 to 10.6 mcg. after two hours with a gradual fall to a level of 0.7 mcg. per cubic centimeter or less after 12 hours.[8]"

Spontin In Treating Staphylococcal Pneumonia —"Ristocetin was used in the treatment of 24 patients with staphylococcal pneumonia, 17 of whom had failed to respond to previously administered antibiotics. Complete clearing of pneumonitis was obtained in 16 patients and significant improvement occurred in two others. Two patients died of pneumonia; four others succumbed to other lethal diseases.[9]"

Spontin In Treating Children and Adults — "Ristocetin completely controlled severe staphylococcal infections in 11 adults and six children who received adequate therapy.[10]"

1. Totals represent published reports and personal communications to Abbott Laboratories.
2. Sixth Annual Symposium on Antibiotics, Washington, D. C., Oct. 15, 16, 17, 1958.
3. Romansky, M. J., and Holmes, R., Successful Short-Term Therapy of Enterococcal and Staphylococcal Endocarditis with Ristocetin—Seven Patients. Preliminary Report, Antibiotics Annual, 1957-58, p. 187.
4. J. A. M. A., 167:1584, July 26, 1958.
5. Bush, L. F., et al., The Use of Ristocetin (Spontin) in Staphylococcal Infections, In Press, Antibiotics Annual, 1958-59.
6. Billow, F. J., et al., Clinical Observations on Ristocetin—A Preliminary Report on its Efficacy and Toxicity in 20 Unselected Severe Respiratory Infections, In Press, Antibiotics Annual, 1958-59.
7. Miller, J. M., et al., Ristocetin in the Treatment of Seven Selected Difficult Cases, In Press, Antibiotics Annual, 1958-59.
8. Asay, L. D., et al., Ristocetin Serum Levels in Children, In Press, Antibiotics Annual, 1958-59.
9. Schumacher, L. R., et al., Experiences with Ristocetin in Staphylococcal Pneumonia: Observations in 23 Cases, In Press, Antibiotics Annual, 1958-59.
10. Terry, R. B., Ristocetin in Children and Adults, In Press, Antibiotics Annual, 1958-59.



WASHINGTON NEWS DIGEST



WASHINGTON, D. C.—If every member of Congress had his way, there would be anywhere from 10 to 15 institutes at the National Institutes of Health in Bethesda. The total now stands at seven, and there is a good possibility that an eighth will be in operation this year or next.

Fifty-eight Senators of both parties joined in sponsoring a resolution that would do three things: (1) establish a National Institute for International Medical Research, (2) create a National Advisory Council for International Medical Research, and (3) authorize $50 million annually for international research programs. Senator Lister Hill (D., Ala.) a leader in health legislation and health welfare appropriations, has taken the lead in pushing this bill.

Four days of hearings brought almost unanimous support of the resolution, only two witnesses complaining it did not go far enough. The administration asked for three postponements to testify. This gave rise to speculation that it either may object on budgetary grounds or dissatisfaction over location of the institute.

Gunnar Gundersen, M.D., American Medical Association president, pledged full support and assistance of the AMA for the project. ". . . we believe that the promotion of international health through research is one of the best means of promoting international cooperation and understanding." He noted "a growing recognition that medicine, with its resources and influence fully mobilized, can perhaps do more for world peace than the billions of dollars being poured into armaments."

The AMA President made several suggestions for the committee's consideration; including (1) that the World Medical Association be included among the international groups to be cooperated with, (2) that due care be taken not to "rob" other countries of experts in medical care and scientific research through support grants not geared to salary differentials. (3) That the program should be primarily one of research itself rather than construction of research facilities. (4) That the greatest care be exercised in setting up the research grants and research programs to avoid overlapping or duplicating.

NOTES:

The Forand bill for hospitalization and surgical services of retired social security recipients has been introduced in only slightly revised form. Its number is H.R. 4700. One change of interest is permitting surgical services to be performed by other than board-certified surgeons. The author says the program will be financed by increasing social security taxes (above increases already scheduled) by one-fourth of 1% for both employer and employee and three-eighths of 1% for the self-employed, both starting in 1960.

More significant than even the introduction of the bill was the statement Mr. Forand filed in the Congressional Record the same day. It was moderate in tone and seemed to be asking the support of all groups. He noted, for instance, that some of his strongest backers have questioned the inclusion at this time of surgical services.

This, he commented, should be weighed by the committee when it takes up the bill.

On hearings, little is known. Neither the House Leadership nor Chairman Wilbur Mills of Ways and Means Committee have given any indication when hearings would be held.

While some committees of Congress have been moving rapidly ahead on health legislation, others like the House Interstate Committee only recently got around to organizing its health subcommittee. It was given a new name: health and safety subcommittee when Rep. Kenneth Roberts (D., Ala.) who headed a special highway safety committee was tapped for the new post. Its area of interest includes public and quarantine, food and drugs, hospital construction, highway and air traffic safety, and air pollution. Mr. Roberts is a lawyer by profession and is now serving his fifth term.

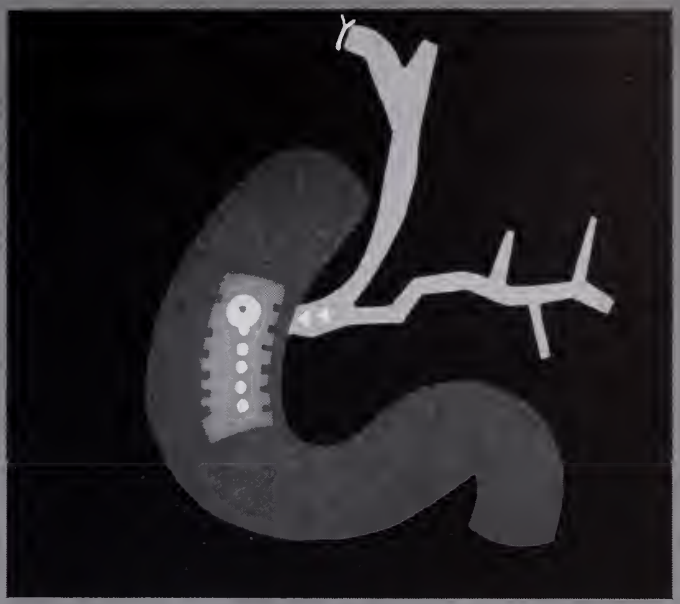
* * * * *

The first woman physician to be honored in Statuary Hall is the late Dr. Florence Sabin of Colorado. She is the first person selected from Colorado. Each state is permitted two statues of distinguished persons. Dr. Sabin was a noted medical researcher and in her later years a public health leader in Colorado. At the unveiling ceremonies in the Capitol, Dr. George Fister of the AMA Board of Trustees represented the association.

* * * * *

Three Republican members of the Senate Labor subcommittee on health would have a two-year study of health needs of all citizens, young and old. The 15-man commission would recommend to the President and Congress necessary legislation to supplement or stimulate broader health protection coverage by existing private and non-profit plans. Senators Javits of New York, Case of New Jersey, and Cooper of Kentucky are the co-sponsors.

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How can the problem of "postcholecystectomy syndrome" be reduced?

A "routine" operative cholangiogram is now recommended in addition to thorough surgical exploration, reducing the number of cholecystectomized patients later presenting the same symptoms as before the operation.

Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

for pre- and postoperative management of biliary tract disorders... **DECHOLIN®** *"therapeutic bile"*

*Hydro*choleresis with DECHOLIN combats bile stasis by flushing the biliary tract with dilute, natural bile...

- corrects excessive bile concentration
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in functional G.I. distress... **DECHOLIN®** with **BELLADONNA**

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DECHOLIN with Belladonna Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.) and extract of belladonna ⅙ gr. (10 mg.). Bottles of 100 and 500.

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In the Treatment of Rheumatic Disorders Greater stability of maintenance dosage minimizes risks of hormonal imbalance

In Sterazolidin, the anti-inflammatory actions of prednisone and Butazolidi are combined to permit lower effective dosage of each. Clinical experien has indicated that patients can be well maintained on this combination ov prolonged periods with relatively low, stable dosage levels of each compone thus minimizing the problems arising from excessively high doses of co costeroids. Other side effects have also been gratifyingly few. Antacid a spasmolytic components are contained in Sterazolidin capsules for the bene of patients with gastric sensitivity.

Sterazolidin®: Each capsule contains prednisone 1.25 mg.; phenylbutazo 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 m homatropine methylbromide 1.25 mg.

Detailed information available on request.

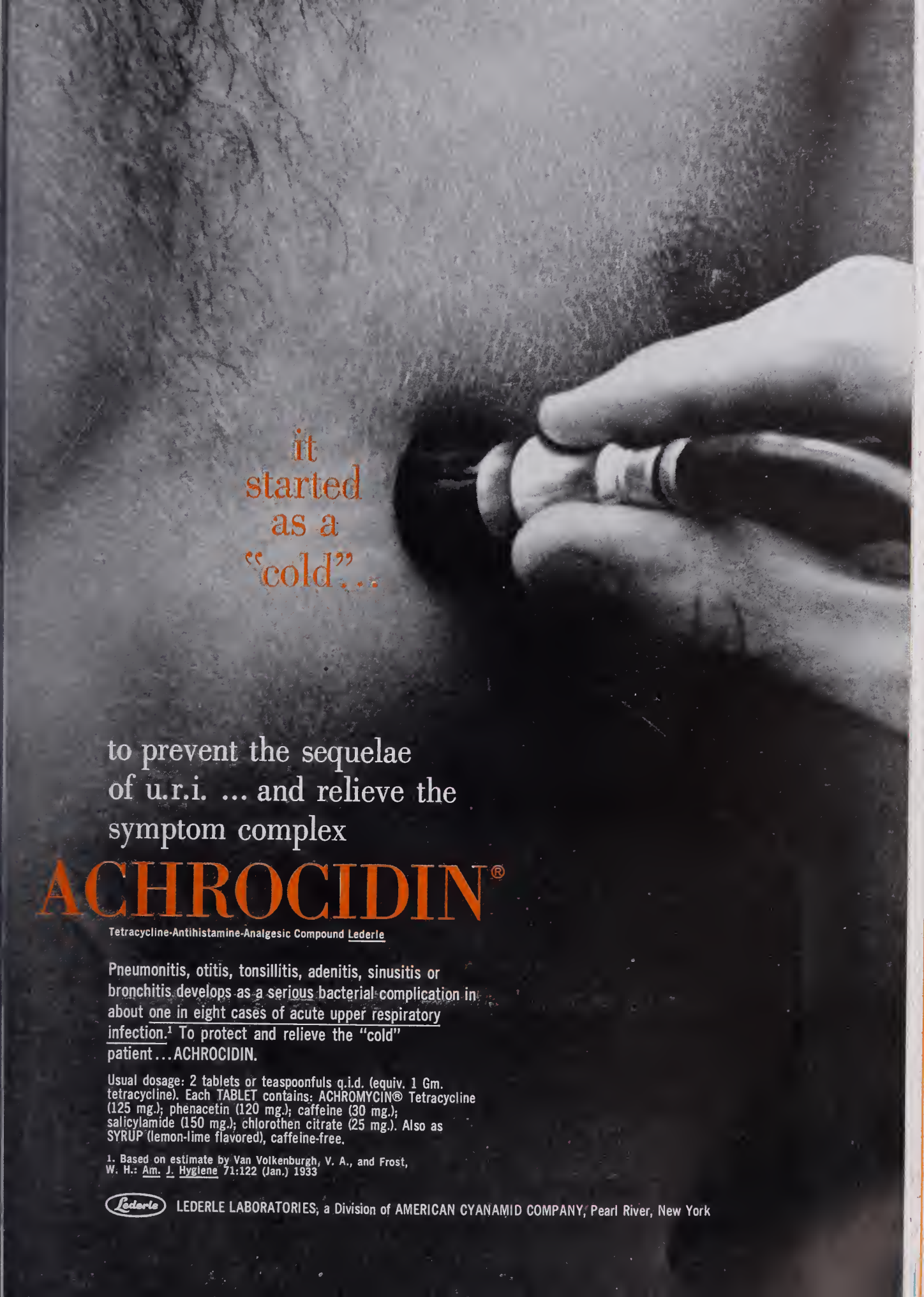
*Geigy's trademark for phenylbutazone—Reg. U. S. Pat. Off.

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to prevent the sequelae
of u.r.i. ... and relieve the
symptom complex

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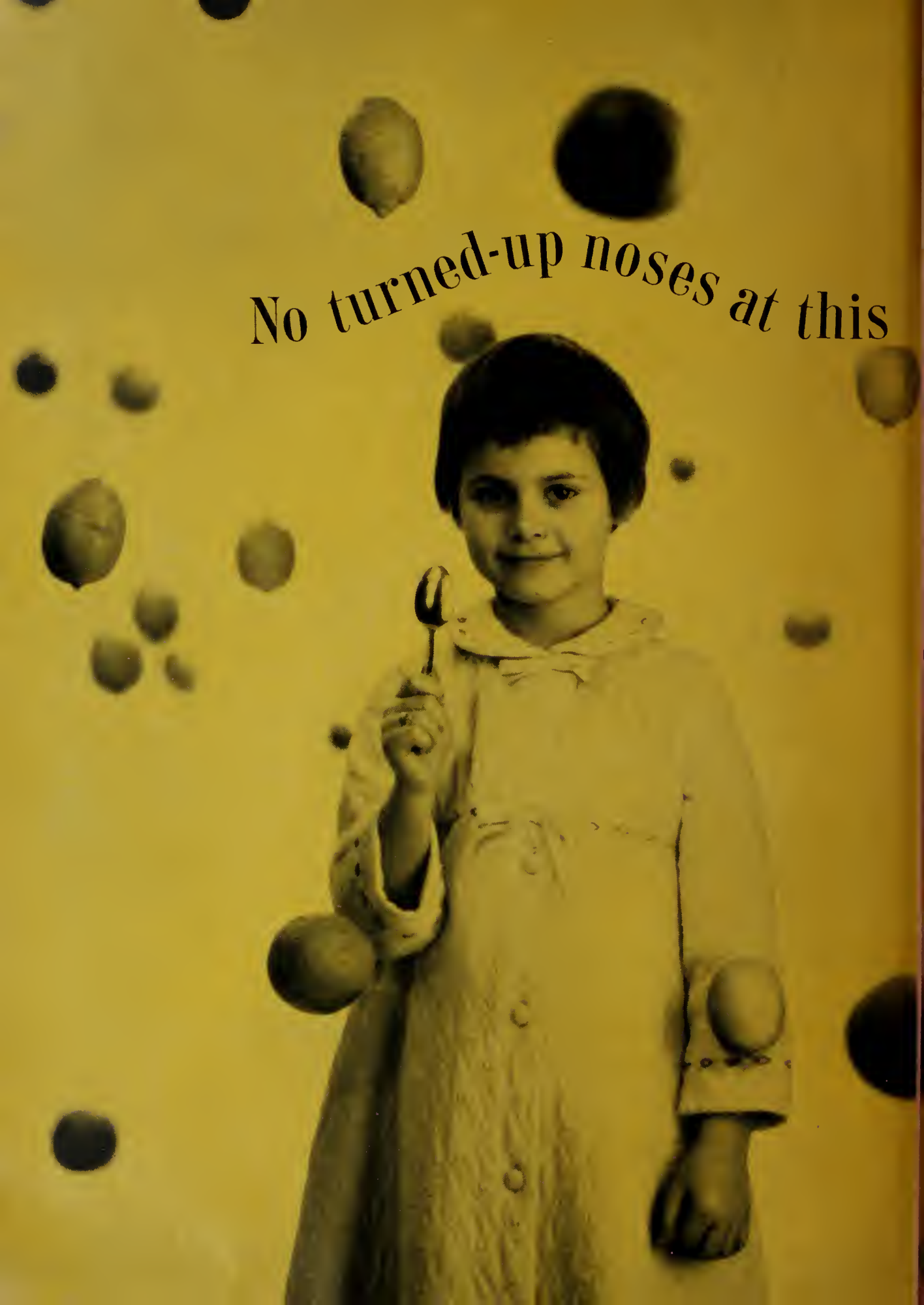
Tetracycline-Antihistamine-Analgesic Compound Lederle

Pneumonitis, otitis, tonsillitis, adenitis, sinusitis or bronchitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.[1] To protect and relieve the "cold" patient...ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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Never an antibiotic better proved against everyday coccal infections

After millions of prescriptions, an unexcelled safety record. High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, Erythrocin is classed as a bactericidal antibiotic.

INDICATIONS: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. DOSAGE: For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm. daily, depending on severity of infection. SUPPLIED: in 60-cc., pour-lip bottles. Each 5-cc. teaspoonful represents 200-mg. of Erythrocin activity.

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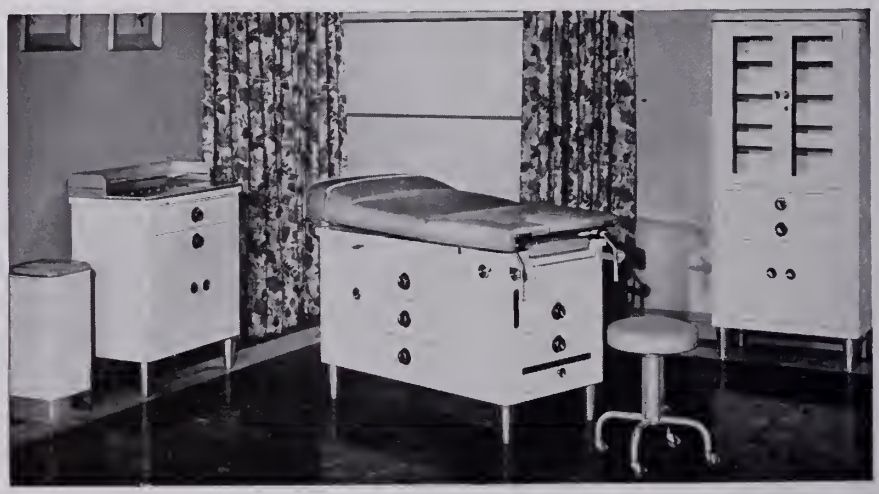
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CAPSULES—14 VITAMINS—11 MINERALS

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THE FESLER COMPANY, INC. • 375 Fairfield Ave., Stamford, Conn.



maintenance therapy is still fundamental treatment

Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.[1,2,3]

Buffered Pabirin provides superior maintenance therapy. It epitomizes fundamental long-term basic therapy since it can be given month after month without serious complications and with minimal problems to patient and doctor alike.

Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. *257*:278 (Aug.) 1957.

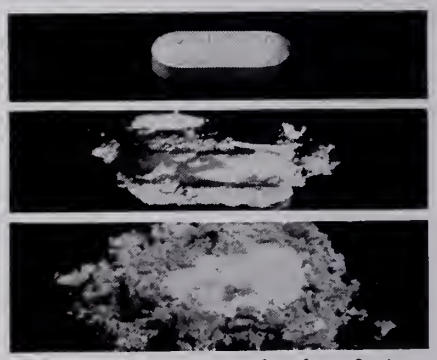
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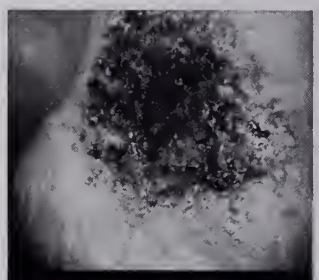
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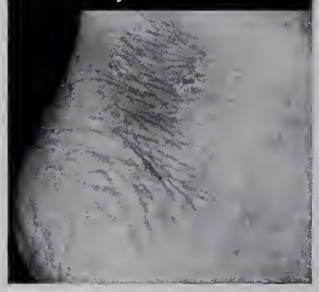
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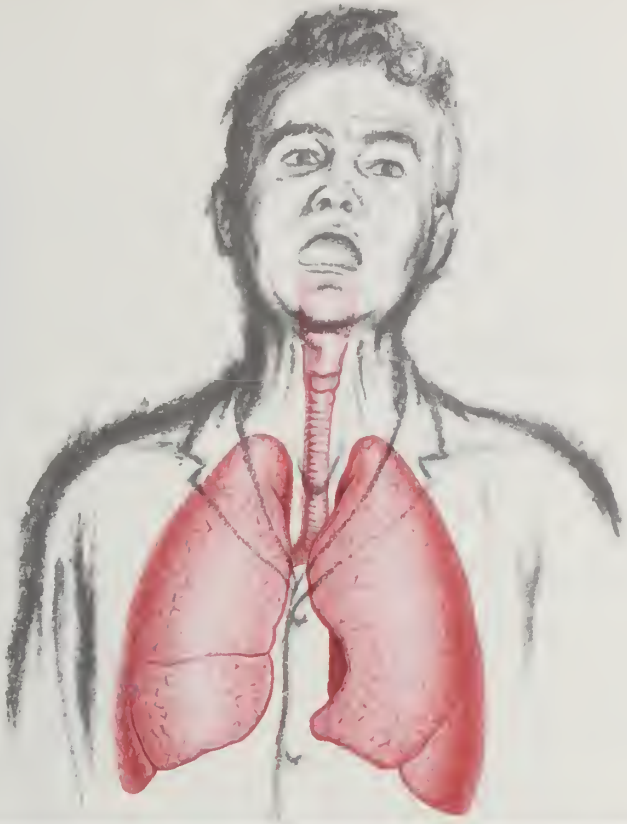
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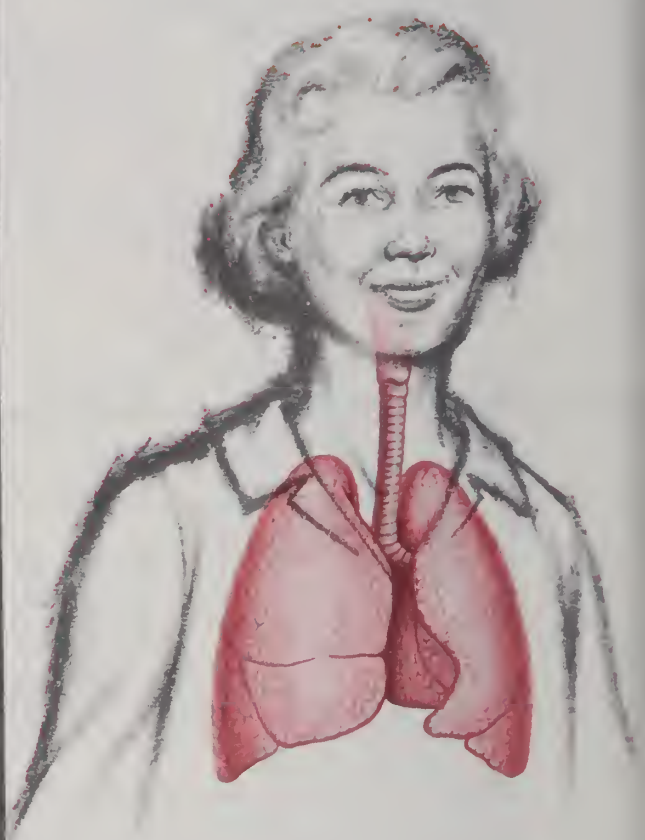
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Total Support During Intracardiac Procedures*

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Columbia, Mo.

THE utilization of complete heart-lung bypass, by means of total support from extra corporeal oxygenation and circulation is becoming increasingly feasible. The heart-lung apparatus provides the means of offering patients with certain acquired and congenital heart pathologies a curative instead of a palliative operation, and increases to almost normal their life expectancy.

Apparatus

Total or complete support of oxygenation during intracardiac surgery is afforded by either of the two currently popular oxygenation apparatus, i.e., the screen or rotating disk type (Gibbon) and the less complex bubble method introduced by Lillehei—De Wall. The rotating disk oxygenator films the blood to a thin layer while contained within an atmosphere of oxygen. The bubble technique introduces oxygen directly into a container of anti-coagulized blood.

Our preference is for the less complex bubble oxygenator. There are several advantages to this type of apparatus. It is less expensive to purchase originally, it requires less floor space in the operating room, has fewer mechanical parts to become defective during utilization, is easily sterilized (thus avoiding the complication of septicemia) and it can maintain the peripheral oxygen saturation at approximately one hundred per cent. It is the ability of the oxygenator to perform satisfactorily during its clinical application that is its most desired characteristic.

The pump or heart most readily adaptable to the bubble oxygenator is the new cabinet model of the Sigmamotor pump described by Lillehei and is co-workers.

Many investigators have proven that it is possible to bypass either the right or left side of the heart, and to completely bypass both the heart and the lung with resumption of adequate voluntary heart action when the heart is reverted into the systemic circulation.

The advantages of the utilization of a pump oxygenator are: 1) surgery can be achieved in a bloodless, quiet field, 2) the circulation can be diverted from the heart for at least eighty-five minutes (our longest interval) with the heart resuming a normal action following total support, 3) more than one defect can be corrected during a single operation such as the complete correction of the congenital defects of tetralogy of Fallot. Specifically, the ventricu-

*Presented at the meeting of the Kentucky Society of Anesthesiologists at the KSMA Annual Meeting on September 24, 1958.

**Professor of Anesthesiology (Keown) and Professor of Surgery (Stephenson), University of Missouri School of Medicine, Columbia, Mo.

lar septal defect and the associated pulmonary stenosis can both be repaired surgically.

There are certain distinct disadvantages of extra corporeal circulation that should be outlined. 1) Mechanical deficiencies of the pump, tubing and oxygenators exist. 2) The patient must be heparinized. 3) Following the use of the heart-lung apparatus, massive hemorrhage is more apt to occur than if bypass techniques were not utilized. 4) Patients must be anesthetized for a prolonged period of time (one to two hours) prior to effective utilization of extra corporeal circulation.

Another disadvantageous finding is the large team required for satisfactory utilization of total support. These include two anesthesiologists, three or four surgeons, two physiologists to assimilate and disseminate the information from the monitoring equipment, two individuals to run the pump oxygenator, two suture nurses, two circulating nurses, and two or more laboratory technicians to collect the samples that are required for complete blood studies.

It seems apparent, therefore, that the utilization of total support is one that will not readily lend itself to community hospitals. It is probable in the future that sufficient studies and improvement in apparatus will afford a more adequate knowledge of what to anticipate and far more adaptable equipment. It can safely be anticipated that the future will bring refinements to both monitoring devices and to the apparatus used for total bypass so that fewer numbers of individuals will be required during the actual bypass phase of intracardiac surgery. We did a cost analysis for each case, and found that the total monies necessitated, exclusive of professional fees, was between $2,800 and $3,000 for each patient. This, of course, means that the actual cost of each case must be subsidized by either federal, state or philanthropic organizations. It is unlikely that a single patient would be able to afford the expense of being treated as a private patient whenever the heart-lung machine is to be employed for the correction of their existent pathology.

Selection of Cases

One of us (Kenneth K. Keown, M.D.) has had the pleasure of anesthetizing one hundred and two patients for surgical correction by means of open cardiotomy for intracardiac defects while supported by the heart-lung machine. The cases have included ventricular septal defects; ventricular septal defects and pulmonary stenosis (tetralogy of Fallot); atrial septal defects; aortic stenosis; aortic insufficiencies; pulmonary stenosis and patients with mitral insufficiency.

The selection of patients for surgical correction should be done by a co-ordinated effort of a selection team. The selection team should consist of the anesthesiologist, the cardiologist, the roentgenologist, physiologist and the surgeon. Medicine is currently filled with team effort endeavors. This is as it should be for progress. The day of one individual being the specialist of the skin and all that it contains is behind us. It is fitting that the anesthesiologist should be a pioneer in the selection of cases for the utilization of this type of apparatus. It is his responsibility to maintain the most nearly normal physiological state possible while the patient is anesthetized prior to, during and after the utilization of heart-lung equipment. The anesthesiologist should know more than any of the selection team members about the effects of the anesthetic agents, the drugs received in the preanesthetic period and their pharmacological effects and the means of maintaining adequate cardiac and respiratory activity prior to and after the operation has been completed.

The variation in the ages of patients in whom we have used bypass and total support techniques have varied from one month to sixty-three years of age. The weight variations were from six pounds (2.7 kg.) to one hundred and ninety-one pounds (86.6 kg.). The duration of anesthesia varied from the period of three hours and thirty minutes to the longest, a period of seven hours and fifteen minutes. The average period of anesthesia for each patient was six hours and twenty minutes. Total bypass time was as short as three minutes in one case, and the longest, eighty-five minutes. The average bypass time was twenty-four minutes.

Anesthesia Management

Meperidine (Demerol®) hydrochloride has been used in conjunction with atropine sulfate for preliminary medication in all patients that have a congenital cardiac pathology and a

systolic blood pressure of at least 100 mm. of mercury prior to induction. The dosage of meperidine hydrochloride has been 1 mg. per pound of body weight, but not to exceed 100 mg. Infants and children who have been adjudged inadequately premedicated by the anesthesiologist from the meperidine hydrochloride have been supplemented by 6-10 mg. of thiopental sodium intramuscularly for each pound of body weight.

The patients with acquired heart disease are premedicated with a short acting barbiturate administered orally or intramuscularly ninety minutes prior to the induction of anesthesia. We prefer the barbiturate in acquired heart lesions because it has less depressant defect on the myocardium and systemic blood pressure than does a narcotic or a synthetic narcotic such as meperidine. Atropine sulfate is ordered sixty to ninety minutes prior to induction of anesthesia. It is most desirable to establish and maintain a ventricular rate that is relatively slow. This affords a more adequate period for each ventricle to fill with blood during diastole. Each ventricular systole will produce a more effective stroke volume and hence a more adequate cardiac output. To a large measure, hypotension can thus be avoided. Atropine sulfate possesses vagolytic properties and severe and untoward arrhythmias during intratracheal aspiration and manipulation can be minimized.

Most severe arrhythmias are due to either oxygen deprivation or mechanical obstruction of the heart. In these instances, the correction is not pharmacologically possible, but requires the establishment of an adequate ingress of oxygen to the alveoli or a cessation of cardiac or tracheal manipulation.

All patients have been subjected to two venous cannulazations prior to induction of anesthesia. Particular care should be utilized in the selection of the area for venous cannulazation of the upper extremity. We prefer the cannula to be placed in the left arm. This is of major significance as in most instances the left subclavian artery is utilized as the arterial limb of the pump oxygenator. Thus, if the venous cannula was inserted into the right wrist, there would be further equipment to impede the anesthesiologist. It is obvious that the blood pressure cuff should not be placed on the left arm if the left subclavian artery is to be used as the arterial limb of the heart-lung machine during bypass time, as it would be impossible to obtain or record blood pressures after the arterial cannulation.

All anesthesia equipment and supplies that may be used during the anesthetization should have been prepared and placed in a readily available location prior to induction. Valuable time and patients' lives are lost when adequate preparation has been neglected. This includes preparation of vasopressors, atropine sulfate, epinephrine, isoproterenol, lidocaine hydrochloride for the treatment of acute major arrhythmias and lanatoside (Cedilanid®) for the treatment of acute heart failure if this should occur.

Technique

The patient is brought to the operating room and the monitoring equipment is placed. We believe the three most essential monitors to be a means of determining peripheral oxygen saturation such as can be obtained by the use of the ear oximeter, a constant recording visual electroencephalograph, and an oscilloscope and recorder for electrocardiographic tracings. Other monitors that are utilized in rarer instances are a recording systemic blood pressure equipment and a pH meter. A base line with each of the monitoring devices should be obtained prior to the induction of anesthesia.

We believe very strongly that it is essential to obtain a preanesthetic blood volume determination on each patient who is to be subjected to total bypass. Blood loss is one of the major surgical complications associated with bypass techniques. We believe the clinical judgment of blood loss to be inadequate, and that the only way the true status can be determined is by actual laboratory calculation of total plasma volume and total packed cell volume with the resultant total blood volume. At the Medical Center of the University of Missouri, blood volume determinations are made by utilizing chrom 51 labeled red cells of type O RH negative blood. Using the current techniques the blood volume can be determined accurately within thirty minutes. It is possible to repeat this evaluation several times, as long as the maximum permissible radiation limits are observed and not exceeded.

Oxygen is administered in the operating room prior to induction. This is a useful guide to note and to correct if possible the reduction of oxygen saturation as a result of the patient's disease. An individual who does not respond to the increase of oxygen saturation during the trial period is not a good candidate for anesthesia or for the surgical correction of intracardiac defects. The oxygen tension should be increased by at least four to eight per cent during the period prior to induction, and if less than eighty-five per cent after five minutes, the contemplated procedure should be cancelled.

The trachea is intubated under direct vision by means of introduction of the largest caliber catheter that can be introduced without trauma. Infants and children are especially prone to develop laryngeal edema from pressure or from trauma. Because of this fact, tubes without cuffs are utilized if the patient is less than ten years of age.

The induction of anesthesia is by means of an ultra short acting barbiturate such as thiopentobarbital sodium followed by a muscle relaxant; my preference is for decamethonium bromide (Syncurine®) or succinylcholine. After the trachea has been cannulated, the lungs are repeatedly inflated with oxygen. Infants are anesthetized using non-rebreathing techniques by means of a cyclopropane oxygen mixture. The level of anesthesia is maintained at the upper first plane, third stage. If the respirations are difficult to control by manual compression of the breathing bag, small doses of Pentothal Sodium® (12½-25 mg.) are added as needed intravenously. After surgery has started citrated blood as needed is added in an effort to remain even with blood lost. The major physiological change with which the anesthesiologist is confronted is a result of the bilateral thoracotomy with resultant bilateral pneumothorax. It is well to recall that the prolonged effect of all anesthesiological techniques in the cardiac patient is depressant.

The adult patient is anesthetized with a Pentothal,® nitrous oxide-oxygen, muscle relaxant sequence. This allows the surgical procedure to be augmented with the electrocoagulation current, if desired, as non-inflammable agents are being administered. After the bilateral thoracotomy has been achieved and the pericardium has been opened, the heart is explored digitally by the operator. At this time, the diagnosis is confirmed, and the preparation is made to place the patient on bypass.

Each patient is administered one and one-half milligram of heparin intravenously for each kg. of body weight. The citrated blood used to approximate blood loss is discontinued and heparinized blood substituted. We ordinarily allow five to ten minutes for complete circulation of the heparin. It is desirable to do a Lee-White study at this time to be certain of the coagulation time. It is considered acceptable if the Lee-White time is increased beyond fifty minutes. We have had two instances in which it was necessary to re-heparinize the patient during the course of the procedure, because of partial coagulation of the blood in the extra corporeal circulation.

The arterial limb of the heart-lung machine should be cannulated prior to the introduction of the catheters into the inferior and superior vena cavae, the reason being that the cannulae form an obstruction to the return of blood to the right side of the heart. This predisposes to an increase in the venous pressure, and, also, with the obstruction inadequate amounts of blood are admitted into the right ventricle, and hence, the pulmonary circulation is depleted as well as the systemic output, with resultant hypotension of the systemic and pulmonic circulations. After the arterial cannula has been introduced, and the air removed from the arterial limb of the heart-lung tubing, the inferior and superior cavae are cannulated. The catheterization of the right side of the heart may be through either the right auricular appendage or right atrial wall.

Immediately after the completion of the cannulation of the arterial and venous limbs, the pump oxygenator is turned on. The patient is then placed on a partial bypass for varying periods of time. It may be as short as one or two minutes or as long as ten minutes before total bypass is instituted. During this interval of time, the anesthesiologist and surgeons are able to ascertain the patency of the cannulae and to make certain the apparatus is in perfect

functioning order. If it is found that the blood volume is rapidly depleted from the heart-lung machine, it may be assumed that the patient has become hypovolemic or that there is a mechanical obstruction. The heart, as a consequence, is not subjected to open cardiotomy until these discrepencies have been corrected. Having ascertained that there are no mechanical defects, that the patient is in reasonable physiological status, total bypass is commenced by complete occlusion of the catheters in the right heart. The venous return is then taken into the blood reservoir and moved by the Sigmamotor pump into the oxygenating chamber, and from the second portion of the pump back into the arterial limb.

Total bypass is maintained with flow rates of from sixty to eighty millimeters of oxygenated blood per kg. of body weight. During the bypass time, the oximeter is carefully observed, and if there is a decrease in oxygen saturation, the rate of flow of oxygen into the oxygenator is increased as well as increasing the total perfusion rate. The oxygen saturated should closely approximate one hundred per cent, but must be maintained above ninety-five per cent. During bypass, a cannula which was previously introduced into the internal mammary artery, is connected to a manometer and the blood pressure determinations noted. The average blood pressure is maintained between sixty and seventy mm. of mercury. We have found it impossible to obtain comparable systemic blood pressures by means of the usual sphygmomanometer and it has been impossible for us to obtain auscultatory blood pressure determinations during the run of the machine. This is the reason we believe cannulation of an artery is indicated. If a mean pressure falls below sixty, it is indicative of inadequate blood flow or hypovolemia.

The decision of cardioplegia is ordinarily made prior to the administration of anesthesia. It has proven to be helpful in patients with ventricular septal defects, either as isolated lesions or as a defect associated with tetralogy of Fallot. The two methods that are currently utilized in most clinics for the production of cardioplegia follow the administration of either acetylcholine as advocated by Lam or potassium as advocated by Effler. The utilization of cardioplegia affords the surgeon a completely bloodless and quiet field in which to work. The limitations, and reasons for limiting its use, are that it is more difficult for the heart to resume normal action after it has been chemically placed in a state of asystole. It appears that the more severely damaged the heart is, the more drastic steps are indicated to achieve beneficial surgical results.

During total support, it is advantageous for the anesthesiologist to either continue to manually inflate and deflate the lung, or to use a muscle relaxant such as succinylcholine that will completely inhibit the muscular activity of the diaphragm. It is extremely important that the diaphragm and mediastinum remain completely inactive during the intracardiac surgical manipulation. It is not unusual for the patient to open his eyes within a period of thirty to sixty seconds after having been placed on total bypass. We have not found it needed to increase the depth of anesthesia during total bypass. It has been our usual practice to administer no anesthetic during this interval, and oxygen alone is used to periodically inflate and deflate the lung to prevent atelectasis. It was interesting for us to find that even though the patient would respond to the command to open and close his eyes at the request of the anesthesiologist, and to occasionally move if they were not completely curarized, that none have recalled any awakeness during the procedure.

Once the definitive intracardiac surgery has been completed by the surgeon, the cardiotomy is quickly closed. Monitoring with the electrocardiogram and the electroencephalogram will reveal the most serious complications. The problems are conduction defects, particularly in intraventricular septal defect from the placement of the suture close to the conduction system. This is usually designated rather quickly by the development of block and can be monitored from the electrocardiogram tracings. If the surgeon has placed a suture in close proximity or around the A-V conduction system it should be brought immediately to his attention, and the suture removed. In event of persistent ventricular conduction defects, we have utilized isoproterenol (Isuprel®) and found

it to be the most efficacious drug to pharmacologically correct major A-V conduction defects. It is obvious that they are best corrected physiologically rather than pharmacologically. Inadequate cerebral circulation or degeneration of the physiological status of the patient is detected first on the electroencephalogram recordings. In the event of complete physiologic deterioration of a patient, the electroencephalographic recording becomes a straight line.

After the cardiotomy wound has been closed, the heart is allowed to resume normal action. There may be a marked hypertension which is probably due to the accumulation of norepinephrine or epinephrine in the circulating blood volume or the heart may be hypotensive. If hypotension and inadequate output of the heart are encountered, we have found it feasible to use a vasopressor containing a mixture of 0.4 mg. of levarterenol and 40 mg. of methoxamine mixed together in a flask of 500 ml. of 5% dextrose and water. The solution is administered intravenously at whatever rate is necessary to stimulate adequate cardiac action. In individuals who receive Levophed® alone, we have been troubled by a high incidence of coupling. This is treated by the administration of intravenous lidocaine in dosages of 25-50 mg. Lidocaine has been particularly useful in our clinic to overcome temporarily untoward cardiac irregularities and arrhythmias. It is well to stress that the use of intravenous lidocaine is for palliation and not for permanent correction of the arrythmias. We have found lidocaine to be particularly helpful in arrhythmias other than coupling that are of a more serious nature such as ventricular tachycardia and ventricular fibrillation. Ventricular fibrillation is best treated by electric countershock with the current passing through both ventricles and the interventricular septum.

In one instance, it was necessary to electrically defibrillate the heart seventeen times. Prior to the seventeenth countershock, we administered 50 mg. of intravenous lidocaine to the three-year-old infant, and following the seventeenth countershock, the heart resumed a normal sinus rhythm. It is always difficult to ascertain what would happen without the administration of lidocaine in this specific instance. I do believe that it is not illogical to assume that after sixteen previous unsuccessful attempts at defibrillation by electric countershock, the lidocaine was most beneficial. It is also interesting to note that the child had an uneventful recovery, and was discharged from the hospital twelve days after completion of the definitive intracardiac surgery for the closure of an interventricular septal defect.

As soon as spontaneous cardiac action has been obtained, the cannulae are removed first from the right atrium to allow better refill, and then from the artery. A heparin neutralizing agent is then administered intravenously. We prefer to use hexadimethrine bromide (Polybrene®) and administer 1.5 mg. per kg. of body weight. Hexadimethrine bromide is a quaternary ammonium salt and a linear polymer. We have been troubled by prolonged periods of hypotension following deheparinization with protamine sulfate. A second advantage to the use of Polybrene has been that its effect is far more predictable and that we have found that the Lee-White coagulation time has reverted to normal within a period of twelve to fifteen minutes, or sooner.

It has been interesting to note that there is a reduction in body temperature in all patients in whom extra corporeal circulation with exclusion of the heart and lungs from circulation. The reduction of body temperature is in direct proportion to the length of time that total bypass has been utilized and is in reverse proportion to the size of the patient.

After hemostasis has been secured and the chest wall has been approximated, the patients are allowed to begin their own spontaneous respiration. At this time, manual compression on the breathing reservoir is used to re-inflate the lungs. This serves a dual purpose; atelectasis should be aborted, and as the lung is inflated, the fluid and blood that has accumulated within the chest should be forced out into underwater sealed containers.

After the patient has resumed adequate voluntary respiratory activity, and after the chest wall has been approximated, each patient is subjected to an elective tracheotomy. This has become essential since the splitting of the sternum makes it difficult for the patient to cough in the postanesthetic period. The accumula-

tion of secretions within the tracheal and bronchial tree has been a major postanesthetic and postsurgical complication. The tracheostomy affords an adequate means for facile aspiration of the tracheobronchial passages. It also affords a patent airway, and a means of administering humidified oxygen and mucolytic inhalants directly into the tracheotomy.

Discussion

The morbidity and mortality associated with extra corporeal circulation has been reduced from thirty-five per cent for the first eighty-nine cases to a hospital mortality of ten per cent in the latter cases of our series.

It is extremely gratifying to all physicians to be able to afford cures to their patients. During the earlier phases of the application of total bypass, the morbidity and mortality rates were higher than anticipated. It still afforded the only possible cure for the patients and the traumatic formative periods were well indicated. It is only by trial and error that progress can be made.

Open cardiotomy with total support during intracardiac procedures is indicated at the present time for selected cases of ventricular septal defect, tetralogy of Fallot, aortic stenosis, pulmonary stenosis and atrial septal defects.

Results that are acceptable by the medical profession as well as the patients' families are with us now.

We can look forward, in the very near future, to marked improvements in the heart-lung apparatus.

Conclusions

The developmental stage of the application of cardiopulmonary bypass have been completed. The physiological changes that occur have been outlined by many authors. Progress will continue to be made until the candidates can look forward to a ninety per cent survival rate.

The use of heart-lung equipment is indicated whenever normal life expectancy is desired for individuals suffering with either congenital or acquired lesions.

The use of extra corporeal circulation represents the difference between palliation and cure in most instances.

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Iridencleisis*

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THE iridencleisis operation is one of the most important weapons in the ophthalmologist's arsenal. It can be employed successfully in almost any type of glaucoma although it is not always the best tool. Meyer[1] reports 207 cases in which this operation was used. In 87 per cent of the wide angle cases tension was normalized. Eighty-five per cent of the subacute, 83 per cent of the shallow angle cases and 65 per cent of secondary cases were normalized. Sourdille[2] reported favorable results in 89.9 per cent of 446 cases. Paiva[3] reported on 200 operations in chronic simple glaucoma with 90 per cent successful.

Effect of Iridencleisis

Authorities are not agreed as to the way in which iridencleisis functions. Weekers[4] says, "In closed angle glaucoma the iridencleisis normalizes the resistance to flow and lowers the ocular tension below normal. Measurement of the coefficient of flow after iridencleisis shows that the formation of aqueous humor is not reduced.

"In cases of closed angle glaucoma the decrease of the resistance to flow is due partly to the opening of the irido-corneal angle to the reestablishment of flow through the surgical fistula into the subconjunctival space. This double action explains the favorable results obtained with iridencleisis in closed angle glaucoma, even when there are irreversible alterations in the irido-corneal angle.

"In simple glaucoma iridencleisis normalizes the resistance to flow and thus the ocular tension. It does not decrease the flow of aqueous. The mechanism of the decrease of the resistance in simple glaucoma after iridencleisis is not yet clear. Apart from the surgical coloboma the irido-corneal angle does not undergo any visible modification. Gonioscopy shows no change to suggest an amelioration of the flow through natural channels. Most authors agree with the hypothesis that the aqueous humor flows into the subconjunctival space along the iris enclosed in the scleral opening. This mechanism certainly operates when the scar is bulky and distended by liquid. In these cases tonography shows a lowering of resistance below normal and tonometry reveals an ophthalmomalacia. Frequently, however, when the surgical scar is small and flat the resistance and the ocular tension are strictly normal. In these cases the question arises whether the iridencleisis has produced a favorable effect on flow owing to some physiological mechanism.

"There is, however, a temporary decrease in the formation of aqueous humor as there is with most operations on the anterior segment. This is also true of cataract extraction. This decreased flow generally lasts for several months."

Meyer[1] reports no parallel found in the anatomy of the cicatrix and resulting tension. Sourdille,[2] using the appearance of the cicatrix as criterion, found the existence of fistulization in 96.5 per cent of cases in which development is favorable and in only 2.2 per cent of cases in which the tension remained above normal. In the course of discussion, however, Kalt upheld the contention, previously defended by Weekers, that there is no relationship between the appearance of the operative scar and the resulting tension; the tension is normal in 88 per cent of cases with a filtering scar and 86 per cent of cases with a smooth non-edematous scar.

Iridencleisis in common with other fistulizing operations frequently produces a cataract. This may come on years after the operation and is thought to be due to a change in uveal metabolism.

Iridencleisis is generally considered to be a

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safer operation than is trephination. The trephine operation is more likely to produce hypotony. The danger of late infection of the filtering scar is many times greater in trephination than it is in iridencleisis.[8]

Cases Reported

We have decided to review the cases upon which we have operated since our return from service some twelve years ago. In this series we are including only the cases from private practice. There is therefore a fair degree of unanimity in the judgment of what type of operation to perform, when to operate and in the surgical skills employed. In spite of this, however, we find surgical techniques changing with the years so that in this series are several minor and one or two major changes in technique of operation. Furthermore we think we have become more conservative in advising surgery and with medical advances have had less need for surgical intervention. Finally it is our distinct opinion that the glaucoma we see today is not as severe as that of ten or twelve years ago. By that we mean that we see more early cases and fewer far advanced ones. The public has become much more glaucoma conscious and so have physicians. It was not unusual ten years ago to have patients come to the office who had suffered from glaucoma for years, but who had never had the diagnosis made. Such cases we are happy to say are becoming increasingly less frequent.

Technique

Since there are a variety of ways in which the operation may be performed we would like to describe the two techniques we have used during the past few years.

Local anesthesia is used in practically all cases. If the patient is a child or if the eye is badly inflamed, general anesthesia or intravenous sedation is used together with local. The use of local anesthetic reduces the amount of general anesthetic necessary, reduces the amount of bleeding and can be used to balloon out the conjunctiva for easier dissection. If the tension is greatly elevated a retrobulbar injection of procaine, four per cent, hyaluronidase and epinephrine is made. Manual pressure is applied as in cataract surgery to soften the eye. Whenever possible the eye has been brought to a satisfactory tension by medical means before coming to the operating room. A bridle suture is passed under the tendon of the superior rectus. The incision is made as high as possible in the conjunctiva of either the upper temporal or upper nasal quadrant. Conjunctiva and Tenon's capsule are dissected down to the limbus. An ab externo incision is made with a Bard-Parker knife about 2 mm. from and parallel to the limbus. The incision is about 5 mm. long.

In the usual type of iridencleisis the next procedure is to separate the iris from the sclera by means of a cyclodialysis spatula. A toothless forceps is then inserted into the anterior chamber and the iris is grasped about midway to the sphincter and pulled out into the incision. A single cut is then made in the iris down through the sphincter so that only one iris pillar remains. No effort is made to turn the incarcerated iris so that the pigment layer faces outward. Tenon's capsule and the conjunctiva are then sutured separately. The eye is dressed with atropine and antibiotic ointment. The dressing is changed daily and the surgeon begins massage on the first post operative day. After a few days the patient may be instructed to massage his own eye through the bandage. The patient is allowed to sit up the day after operation, and is usually ready to go home a week after the operation.

Stallard Technique

During the past few years one of us has been very favorably impressed by the Stallard iridencleisis and has employed it in perhaps a dozen eyes, partly reported here. This operation is adequately described by Muelberger and McDonald[5] in "Archives of Ophthalmology" 1956. Briefly the difference between this operation and the one described above is as follows.

After the scleral incision has been made and a pathway into the anterior chamber opened with a spatula, a traction suture is placed in the anterior lip of the sclera. Two converging cuts are made in the sclera toward the limbus so that a flap with its narrower border hinged at the limbus is created. The iris is then drawn out with a toothless forceps and a flap with its base upward is cut in the iris. The sphincter is not cut and a round pupil remains. The flap is left protruding through the scleral opening and

the wound closed by suturing Tenon's capsule and conjunctiva. The authors state that no massage is necessary, but we have not found that to be the case. The authors report 62 cases with tension controlled in 58. Three of the four failures were secondary glaucoma.

Classification of Cases

Our series consists of 136 operations performed on 98 patients. Only those who have been followed for at least six months or who have had some other operation such as cyclodiathermy or enucleation were tabulated. Of these there were 77 wide angle, 26 narrow angle, 6 congenital, 16 questionable or mixed and 4 secondary glaucoma from various causes.

Cases were divided into early, moderately advanced, far advanced and absolute, according to the deterioration in the fields. The classification set forth by Kronfeld and McGarry was used. As a criterion of success the intraocular tension was used. If the pressure was normalized by the operation alone the success of the surgery was considered to be ++++, if pressure was normalized with the help of miotics +++. If both miotics and some aqueous inhibitor was used ++. If the tension was not controlled by any means but the patient made more comfortable by the operation it was rated +.

The 50 patients with wide angle glaucoma had an average age of 62. Of 17 early cases, 12 (70%) are controlled with or without miotics. Of 15 moderately advanced, 10 (66%) are controlled and of 34 far advanced, 27 (79%) are controlled. All but 6 of the 72 eyes were improved by operation. Twenty six had cataracts. Six of these had cataract extractions later—all successfully. In one patient a cyclodialysis was performed on both eyes three months after the iridencleisis. One patient had cyclodiathermy after having had hyphema.

There were 25 operations on narrow angle glaucoma with sufficient follow-up period. The average age was 61½. Nine early, 2 moderately advanced and 3 of 6 far advanced were controlled with or without miotics. There were 8 cases in which we could not determine the state of advancement from our records. Of these, 6 were controlled and 2 unimproved. One case of absolute glaucoma was not improved. There were 9 cataracts of which 4 were later extracted. Ten patients with average age 62 had a primary glaucoma which we were unable to classify as to the type. Sixteen operations were performed on these 10 patients. Two of these were early, one was controlled with miotics and Diamox®, the other was not controlled until a second iridencleisis was done. Of five moderately advanced, two were controlled with miotics, two with miotics and Diamox and one required a second iridencleisis. Two were far advanced, both were controlled. Four were absolute, two being uncontrolled and two controlled.

Comment

One-hundred-twenty-three eyes which have had iridencleisis operations have had a six month or more follow-up period. Fifteen or 12.3 per cent of the operations were not successful in improving the eye. In 90 (70 per cent) the tension was controlled with or without medication. The remaining 18 eyes were considered to be improved by the operation even though the tension was not brought to within normal limits. It must be remembered that this operation is advocated only in those eyes which we believe to be uncontrollable medically. In other words, in our opinion all of these eyes would sooner or later have been lost without some operation.

It is interesting to note that insofar as pressure is concerned it makes little difference as to when the operation is done. Those with far advanced glaucoma were normalized as easily as those with early glaucoma. It has been shown, however, by Bloomfield and Kellerman[7] that operation on an eye in which the fields have been greatly reduced is a hazardous undertaking. Such eyes—those with fields reduced to 10 degrees are more apt to retain their vision with uncontrolled tension than with controlled tension after surgery. There were several cases in this group which would substantiate this claim.

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The Management of Chronic Lymphatic Leukemia*

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OUR present concept of chronic lymphatic leukemia began with Virchow's observations in 1846.[1] At present the disease is generally thought to be a fatal neoplastic process of unknown etiology, characterized by widespread proliferation of the lymphocytes and their precursors throughout the body, with an accompanying lymphocytosis. Cases which qualify for this diagnosis range from those with only a mature absolute lymphocytosis to those with the same finding and in addition enlargement of lymph nodes and multiple other complications arising from the widespread neoplastic process.

My purpose here is to review experiences in handling some of 37 such cases seen at the Lexington Clinic over a 15-year period. Certain cases are chosen to demonstrate the common complications somewhat peculiar to this disease.

Data on Patients

The majority of patients were male, 21.5 per cent being female. The average age at the time of diagnosis was 62.9 years. The youngest patient was 34 years and there were three who were 79. While survival statistics are of some interest in a series of this type, they are of little value when applied on a prognostic yardstick to individual cases. In a heterogeneous group such as this, economic and geographic factors appear to cause considerable variation of the duration of the disease from the time diagnosis is made and also of the calculated probable survival time. These factors probably also account for the fact that only 15 of this group were observed over a significant period of their disease. Of these the average survival was four years (seven of the group are still alive). The average probable duration of disease of those who expired was 5.2 years. Reliable statistics of larger series vary from 3.2 to 5.4 years.[2] The longest duration on record was 29 years. The longest survival in this group was 9.65 years. Of the 37 cases, there were 14 known deaths. The causes of death are summarized in Table I.

Table I

CAUSES OF DEATH

Chronic lymphatic leukemia (without other cause)	5
Roentgen therapy (?)	2
Extractions	1
Splenectomy	1
Carcinoma of the colon	1
Carcinoma of the prostate	1
Pneumonia (Pseudomonas)	1
Miliary tuberculosis	1
Cryptococcosis (cerebral)	1
TOTAL DEATHS RECORDED	14

Comments on Specific Therapy

It is probably superfluous to emphasize the importance of the doctor-patient relationship to these people. A simple explanation of the disease process and the objectives of treatment usually bolsters the patient's morale and serves to indoctrinate him to a chronic incurable disease in much the same way as do similar explanations to patients with diabetes mellitus, rheumatoid arthritis and peptic ulcer. The objective should be to maintain normal activities without unnecessary restrictions. As Osgood points out, a good criterion for successful management of this disease is the number of days out of the hospital at normal activity. During inactive phases of the disease semiannual examinations are frequently all that are needed. During more active phases weekly visits may be desirable.

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The choice of specific therapeutic agents is limited to conventional roentgen therapy (regional or total body irradiation), radiophosphorus (orally or intravenously), and chemotherapeutic agents. Of the 15 patients followed here, nine received some type of roentgen therapy, four received radiophosphorus, two chemotherapy, and three steroids. Roentgen rays have been used for this disease since the turn of the century. The mechanism of their action is inhibition of mitosis.

In a recent panel discussion on therapy, authorities from three different centers did not entirely agree on precise methods of managing this disease.[3] In general, they agreed that the early asymptomatic cases should not be treated specifically. With the appearance of general symptoms or mechanical difficulties due to pressure the agent of choice is generally considered to be irradiation. When there are large aggregates of lymph nodes and/or enlargement of the liver or spleen, regional roentgen therapy is probably most feasible.

The notable exception on the above panel is Osgood's use of "titrated" radiophosphorus in all cases regardless of clinical findings or stage of disease. The results with this program have been excellent and certainly seem to indicate that there is no justification for delaying treatment after symptoms arise.[4] This method is outlined in Table II. Radiophosphorus has a half life of 14½ days. The highest concentration occurs in the tissues with the heaviest infiltration. No radiation sickness occurs and either the intravenous route or oral route may be used.

Table II

TREATMENT WITH RADIOPHOSPHORUS

Initial Therapy

1. 1.3 mc. of p^{32} intravenously when diagnosis is made.
2. Dosage once a week initially until ideal maintenance is found:

Visit	WBC	Dose	Next Return
1		1.3 mc.	1 week
2	drop 20-30%	same	2 weeks
	drop greater than 30%	none	1 week
	Rise	increase by 20%	1 week

3. Increase interval by one week and dose appropriately until WBC number 15,000 ± 5,000 (usually 3 to 4 mc. every four to twelve weeks).

Of the chemotherapeutic agents, triethylene melamine (TEM) has been most widely used. It is a chemical congener of nitrogen mustard and can be given orally. Mustards and ethyleneamines interfere with the polymerization of nucleic acides, an action similar to that of ionizing irradiation. The drug is given on an empty stomach one hour before breakfast. A dose of 2.5 mgms. should be tried and thereafter 2.5 to 5 mgms. is usually given weekly or every two weeks, with careful attention to leukocyte count, hemoglobin and platelets. CB—1348 is a similar drug of more recent vintage and is probably less toxic.

Beneficial results of all types of therapy are usually manifested by: (1) a decrease in the number of circulating white cells; (2) a reduction in marrow infiltration permitting more normal hematopoiesis, and (3) a reduction in the size of lymph node masses, spleen, and liver.

Specific Treatment of Cases

In these 15 cases treatment was started only when symptoms attributed to the disease occurred. Regional roentgen therapy was used in nine cases. A high white count did not necessarily indicate that treatment was to be started. This was particularly true when there were no systemic enlarged nodes or splenomegaly. With a rising white count and evidence of lymphoid proliferation, symptoms of malaise, weakness, night sweats and weight loss usually occurred and treatment was started.

Our initial treatment in most of these cases was a small amount of deep x-radiation given in daily doses of 100 to 200 r for a total of 600 to 800 r over the spleen. With a white count of 300,000 there was usually a reduction of the count by 50 per cent in a week or ten days. The lymph node enlargement usually responded to a total dosage of 600 r broken into two or three treatments.

Patients in whom there was no lymph node or spleen enlargement and who needed treatment were given spray irradiation or radiophosphorus. In the former instance a small amount of radiation, not to exceed a total of 75 r, was given anteriorly and posteriorly and divided into two or four treatments. With this radiation

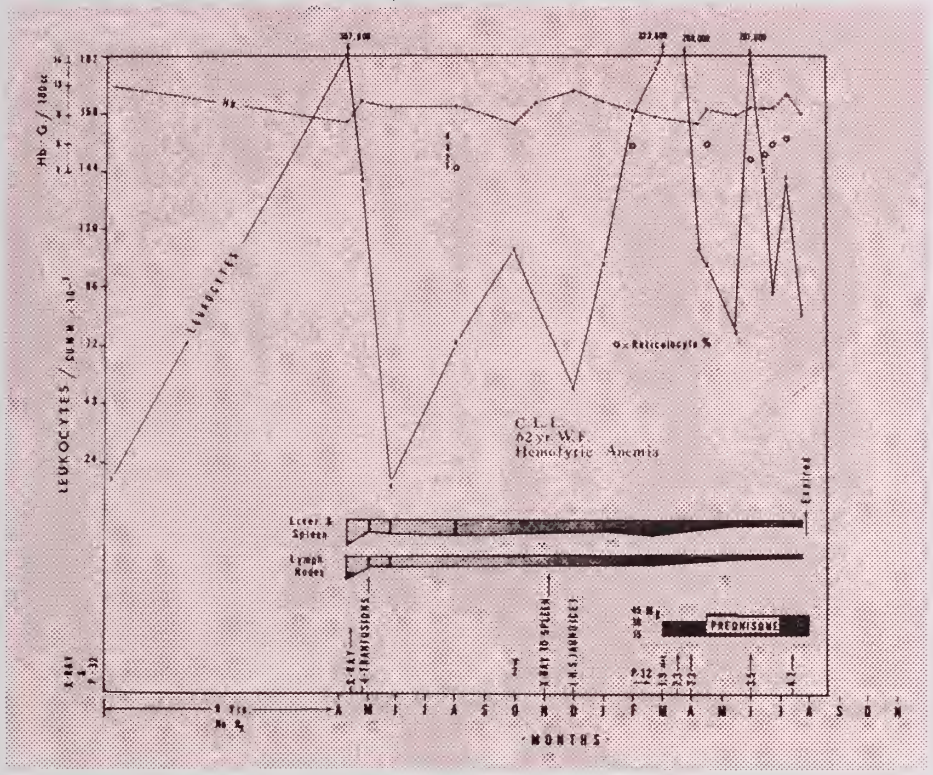


Fig. 1

This 62-year-old white woman received regional roentgen therapy after eight years without specific treatment. An elevated reticulocyte count and an active erythroid element in the marrow were interpreted as indicating a hemolytic anemia. There was good response to steroid therapy. "Titrated" radiophosphorus was successful in controlling a very generalized process. The terminal event was lobar pneumonia and bacteremia (Pseudomonas).

it is extremely important that the leukocytes, platelets, and hemoglobin be followed carefully at weekly intervals for a month. The use of this program has been coordinated in individual cases with titrated doses of radiophosphorus (Fig. 1). Chemotherapeutic agents were used in only a few instances and it is felt that no conclusions can be derived from such limited experience.

Complications

The miscellaneous and hematologic complications encountered in this group of patients are listed in Table III. The latter deserve special comment.

Anemia: Anemia invariably accompanies chronic lymphatic leukemia at some time during its course. Unfortunately it has frequently been considered an invariably bad prognostic sign. In most cases the anemia is probably due to replacement of normal marrow elements by leukemia cells (myelophthisic). Occasionally infiltration is so extensive that it is impossible to aspirate by the usual technique. Splenectomy was done in one such case despite lack of the usual evidence of increased blood destruction, and the course has been favorable (Fig. 2). Frequently such anemia will respond to treatment with either regional or total body irradiation, or radiophosphorus. This man had a remarkable revival of normal marrow elements in the fifteenth month approximately three months after a second course of roentgen therapy. During the probable four-year course of his disease he has missed very little time from work.

Acquired hemolytic anemia: This is a rather common complication of chronic lymphatic leukemia.[5,6,7] The exact mechanism is uncertain but is probably similar to that in idiopathic cases. Survival studies of transfused red cells

Table III
COMPLICATIONS

Miscellaneous	Number of Cases
Miliary tuberculosis	1
Pulmonary tuberculosis	1
Severe secondary "fibrositis"	1
Carcinoma of colon	1
Cryptococcosis (cerebral)	1
Thrombophlebitis	1
Cerebral hemorrhage	1
Herpes zoster	1
Carcinoma of prostate	1
Posterior column disease	1
Hematologic	
Anemia (myelophthisic)	12
Anemia (acquired hemolytic)	3
Anemia (x-ray hypoplasia)	1
Leukemia cutis	1
Thrombocytopenic purpura	3
Reduced gamma globulin	1
Acute leukemia	1?

have shown a shortened life span. Treatment with steroids (Prednisone 10-15 mgms. every 6 to 8 hours) usually gives a good response, as one of the cases from this series demonstrates (Fig. 3). The mechanism of the bleeding following splenectomy in this case was not determined, but it was probably not due to lack of platelets. It seems impossible at the present time to form an exact criterion for selecting cases for splenectomy.

Increased susceptibility to infections and reduced gamma globulin: Persons with chronic lymphatic leukemia are notoriously prone to infections, most frequently bronchitis and bronchiectasis. Osgood has suggested use of a small daily dose of sulfonamide as a prophylaxis.[4] A broad spectrum antibiotic should be chosen instead of one effective only against gram-positive cocci. A number of cases have been found to have evidence of a reduction or absence of gamma globulin production.[8] In only one of our cases was there significant reduction with accompanying clinical susceptibility to infection.

Splenectomy

Splenectomy may be of benefit in selected cases. It seems that the criteria should include frank hemolytic anemia and/or thrombocytopenia without megacaryocyte damage or replacement. While the one patient here with these criteria did not survive splenectomy (Fig. 3), the other patient, who seemed a poorer candidate, had an excellent result (Fig. 2). Candidates for this type of surgery should be individually and conservatively selected.

Summary

1. A group of 15 cases from a series of 37 has been reviewed briefly with emphasis on the course, management, and treatment of the complications of chronic lymphatic leukemia.

2. Chronic lymphatic leukemia can be managed by using a variety of specific therapeutic

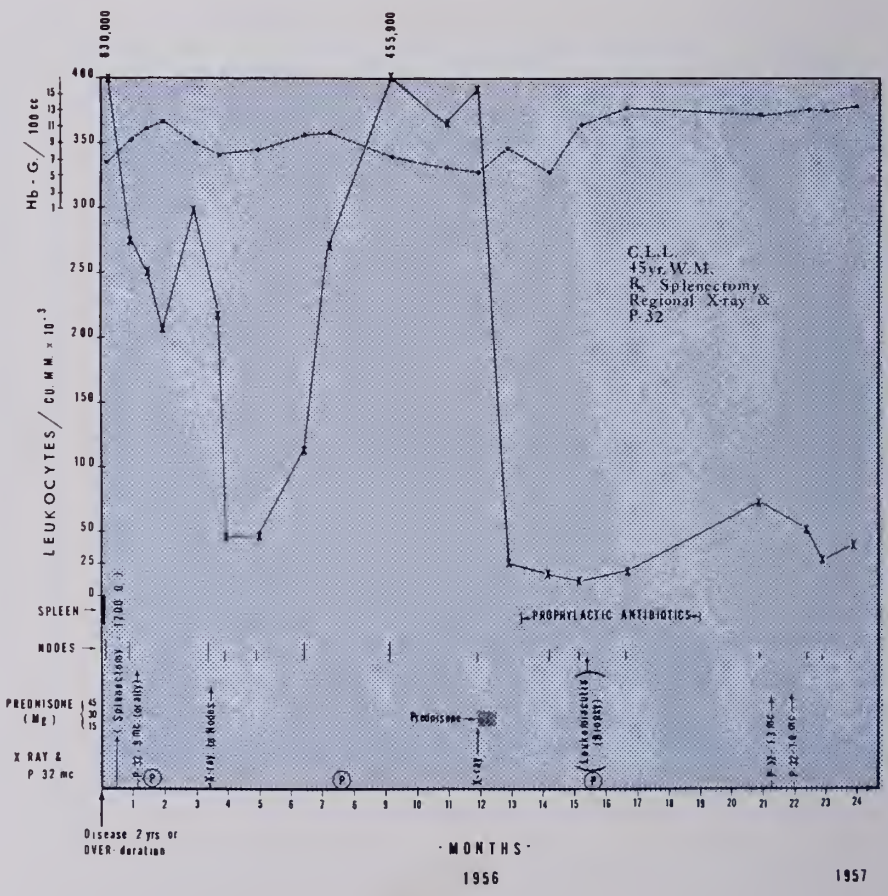


Fig. 2

This 45-year-old white man made a good response to splenectomy despite evidence that the anemia was probably myelophthisic. At present his general health is good except for mild symptoms from leukemia cutis.

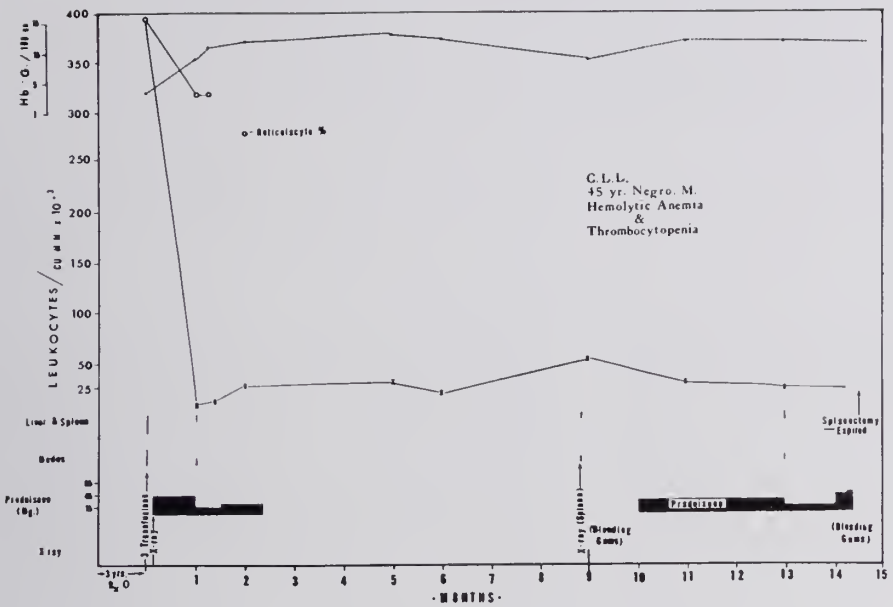


Fig. 3

This 45-year-old negro male had an elevated indirect serum bilirubin, reticulocytosis and an absence of obvious blood loss. Severe febrile reactions accompanied the two initial blood transfusions. Response to steroids was excellent. In the last few months thrombocytopenia developed without megacaryocyte damage. He did not survive splenectomy.

agents. While little seems to be gained by active treatment during asymptomatic phases, early treatment when indicated probably is not detrimental. No conclusion can be drawn from the data reviewed as to a specific plan for therapy suitable for every case encountered. It is probable that no single therapeutic approach is superior, although irradiation by some technique is probably the best single agent we have at present.

3. The most common hematologic complications are discussed and demonstrated. One should be aware of the high incidence of acquired hemolytic anemia accompanying this disease. Persons in whom recurrent infections occur commonly should be placed on antibiotic prophylaxis.

4. The course of this disease is probably erroneously represented by the statistical findings of any small or large group of heterogeneous patients. An optimistic attitude, both by the patient and the physician is completely justified and beneficial.

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A Five-Year Follow-Up Study of Ischiofemoral Arthrodesis*

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REPORTED herein are the results obtained in a follow-up study of all patients having ischiofemoral arthrodesis in Kosair Hospital from 1946 through 1951. A total of sixteen cases were found which would fit into the category of ischiofemoral arthrodesis. Replies to postal inquiries were obtained from thirteen of these patients and twelve of them returned for personal examination by the author. Of those who failed to return, one had died of causes unrelated to surgery, two failed to reply, and one was unwilling to return because of advanced pregnancy.

The twelve patients who were personally examined and whose X-rays were reviewed by the author, form the basis for the main body of this report. Additional notes are appended concerning the four patients who did not return for examination.

The purpose of this study was to learn our frequency of success, both structural and functional, and to learn, if possible, the reason for failures which were encountered. The factors considered were: 1) Structural result, 2) Type of procedure, 3) Indication for surgery, 4) Sex, 5) Age at time of surgery, 6) Duration of symptoms prior to surgery, 7) Type and duration of immobilization following surgery, 8) Frequency of cast change, 9) Medications used, 10) Length of follow-up, 11) Presence of associated lesions of the same disease, 12) Hip surgery prior to ischiofemoral arthrodesis. Condition of donor areas for bone grafts, present occupation and activities of patients, and complications other than failure of fusion are also discussed briefly.

There were seven Brittain procedures and five Trumble procedures. In all Brittain procedures and in one of the Trumble procedures, autogenous bone was used for grafts. In the other four Trumble procedures homogenous bank bone grafts were used. Five of the seven Brittain procedures succeeded and two failed. Only two of the five Trumble procedures succeeded. In each of the unsuccessful Trumble procedures bank bone had been used. In each of these, not only did the hip joint fail to consolidate, but the grafts were, also, partially or completely absorbed.

In the patients with solid hips following the fusion procedure, it was noticed on X-rays that the grafts had hypertrophied to as much as six times the original size. The larger ones had formed new cortex on all sides and had centers apparently filled with cancellous bone. New lines of stress with increased density were seen through the upper end of the femur and in the lower portions of the pelvis. In most, diminished density was noted in the head and neck of the femur and in the lateral portions of the pelvis.

The indication for surgery in nine patients was tuberculous arthritis; in two, undiagnosed destructive arthritis; and in the other, congenital dislocation. Of the twelve, seven had biopsy and five had cultures from the hip area.

There were five male and seven female patients. In four of the male patients the procedure succeeded and one failed. In three of the female patients the procedure succeeded and in four it failed. This gives a preponderance of success in male patients, but the group studied is too small to allow valid statistical conclusions.

Age at the time of surgery ranged from seven to twenty-two years with an average age 11.1 years. Among the patients with successful

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fusion procedures, the average age was 12.3 years with a spread of seven to twenty-two years. Among those with failure of the surgical procedure, the average age was 9.6 years with a spread of seven to fourteen years. Arbitrarily assuming age eleven, the average age, as a reference point, it was found that of the seven patients that age and under, three had successful procedures. Of the five patients, age twelve years or older, four had successful procedures and one failed. Though no statistically significant conclusion can be drawn from these figures, the higher incidence of failure among the younger patients is in keeping with the belief that procedures for arthrodesis are less likely to succeed in the very young.

The longest duration of symptoms prior to surgery was ten years. (This excludes the fourteen-year-old patient with congenital dislocation of the hip). The shortest duration of symptoms prior to surgery was two years; the average 5.4 years. It was found that no consistent correlation could be established between duration of disease and likelihood of success. The same seemed true of duration of immobilization and frequency of cast change after surgery. All twelve of the patients had hip spica immobilization and about half of them had bilateral long leg hip spicas initially after surgery. Duration of immobilization varied from six to thirty months post-operatively. Casts were changed at three and four month intervals.

It was also found that no significant correlation could be established between use of anti-tuberculous drugs and likelihood of success in those patients with tuberculous arthritis. Among the six tuberculous patients in whom solid hips resulted from surgery, only one had received streptomycin at any time during treatment. Among the five failures, three had received anti-tuberculous drugs.

The shortest follow-up (excluding those patients with unsuccessful procedures and subsequent alternative fusions) has been five years and two months. The longest follow-up period since surgery has been ten years and three months.

Fortunately, only two of these patients had demonstrable active tuberculous lesions other than those in the hip. One had tuberculous spondylitis, successfully fused prior to hip surgery, and another patient had renal tuberculosis treated by nephrectomy subsequent to hip surgery. Both patients obtained solid hip fusions.

No significant correlation could be established between previous surgery on the hip and rate of success in ischiofemoral arthrodesis. Among the seven successful cases, two had had previous attempts at surgical fusion and two had had previous osteotomies, one of these twice. Among the five failures, one had had a previous attempt at surgical fusion, one incision and drainage, and two had surgical biopsies.

Although probably of no real significance, it was noted that eight of the cases had indication for fusion of the right hip. Six of these succeeded while two failed. Four fusions were done on left hips. One succeeded and this one was done for congenital dislocation of the hip.

Follow-Up

In the total group of twelve patients, only two had symptoms referrable to the back. The complaints in these two were of dull low backache and fatigue related to excessive physical activity or to assuming the same position for prolonged periods. X-rays of one of these patients showed minimal degenerative joint changes in the lower lumbar spine. If another follow-up study could be made in twenty years on these same patients, doubtlessly there would be found several more patients with back symptoms and findings.

In all patients the surgical scars were well healed and non-tender. In the eight in whom autogenous grafts were employed at surgery, six of the donor areas were found to be completely healed and without X-ray evidence of removal of bone. In the other two patients with autogenous bone grafts, X-rays revealed moderate roughening of the surface of the tibia or fibula. There were also two or three small areas as yet unregenerated, ten and six years after surgery. The unregenerated areas were no larger than one-half centimeter in diameter. The regenerative power of the tibia was unusually well demonstrated in one of the patients. Eight months prior to hip surgery this patient had a spinal fusion for tuberculous spondylitis. The same donor area in the tibia was used on both occasions. Current X-rays show no

evidence of removal of bone from the area and no roughening of the cortex. None of the patients suffered fracture or other complication in the donor bone.

All of the twelve patients lead active lives. They are employed at such occupations as farm laborer, stock boy in a store, assembly line worker, housewife, and the younger ones as high school students in regular classes.

Only two patients feel that they are hampered in the activities they would like to undertake. It is apparent in interviewing these patients that the limitation in these two is primarily one of motivation. Three of the female patients have had children, apparently without difficulty in delivery.

Complications in Successful Cases

There were three complications of major importance among these patients. There were 1) deformity of the hip, 2) shortening of the affected extremity, and 3) instability and/or deformity of the knee.

All of the seven patients with solid hips had flexion deformities of the hip ranging from 20 degrees to 38 degrees (clinical measurement). Four of them had adduction deformity in addition ranging from 5 degrees to 20 degrees. No consistent correlation could be established between degree of deformity and duration of disease, age at onset of disease, age at time of surgery or position of the limb at the termination of surgery.

With one exception, shortening in the affected extremity ranged from 1/4 inch to 3⅜ inches. However, this is difficult to evaluate since four of the seven patients had had surgical procedures to delay or arrest growth in the unaffected limb. The greatest amount of shortening was found in those patients who had onset of disease at the earliest age and had been immobilized the longest prior to surgery. There was also noted a tendency for shortening to be greater in those patients who had fusion of the hip at the earlier ages. The present shortening is probably of permanent degree since X-rays reveal that the epiphyseal lines are closed in all patients.

In all seven of these patients with solid hips, the knee of the affected extremity was unstable. This was most often a lateral instability, but was often combined with rotary and antero-posterior instability. Those with the greatest instability also have X-ray findings of distortion of the femoral and tibial condyles and enlarged, distorted and lengthened upper end of the fibula. Four of the seven had deformity of the knee in addition to instability. This deformity was one of flexion, valgus, external rotation, or a combination of these.

Four of these seven patients with solid hips had instability of the knee on the opposite side. In none was the instability as marked as on the affected side. Only two of the knees on the side opposite the solid hip were found to have deformity. In one, the deformity was 20 degrees recurvatum; the other, mild varus following a stapling procedure.

Gait of these patients was observed. Marked limp was noted in three of the seven with solid hips. The limp appeared to be due to shortening and/or adduction of the extremity. Moderate limp was noted in three others with solid hips, apparently from the same cause. One had slight limp due to shortening, and this is compensated by walking on tiptoe. She refuses lifts on the shoe.

Complications in Unsuccessful Cases

Failure of fusion occurred in five of the twelve cases. Of these five, two had subsequent successful iliofemoral procedures. These were done at intervals of ten and twelve months after ischiofemoral arthrodesis. They were subject to the same type of complications post-operatively as were the patients with successful ischiofemoral fusions.

Among the other three patients with failure of fusion, the current X-rays revealed partial or complete absorption of the grafts. One had a near-normal appearing femoral head with a normal joint space. The other two had distorted and partially destroyed femoral heads with narrowed, irregular joint spaces but no evidence of active disease. Two had flexion-adduction deformities with loss of rotation at the hip. The third had no clinical deformity and excellent motion. Shortening in the affected extremities ranged from 9/16 inch to 4⅝ inches. However, two of the three patients had knee stapling procedures. Two of the three had severe gluteal limps, the third a "hitch" in the gait, apparently due to the shortening of the extremity. One had no deformity

or instability of either knee. The second one had a moderate bowleg deformity and an enlarged, distorted upper end of the fibula and gross instability of the knee on the affected side. The third patient had a fixed flexion-varus deformity of the knee on the affected side with marked instability. In addition, she had an equinovarus deformity of the foot and ankle on the affected side.

Patients Lost to Follow-Up

As has been previously stated, there were four additional patients with ischiofemoral arthrodesis who were not examined in the study. From a review of their charts, it was learned that all four had Brittain fusions for tuberculous arthritis. All four succeeded in obtaining solid hips. There were two male and two female patients. Two were age twelve and two were age thirteen at the time of surgery. Duration of symptoms prior to surgery ranged from one to seven years. Immobilization in casts post-operatively lasted from seven to ten months. Cast changes occurred at four to six month intervals. Three of the four received routine medications, whereas one received streptomycin and PAS during the post-operative period. Follow-up period ranged from one year and seven months to three years and eight months. None of the patients had associated tuberculous lesions demonstrated. Two had not had previous hip surgery; the other two had each had manipulation of the affected hip and an unsuccessful attempt at surgical fusion. In two of the patients the graft donor areas were said to be healed. There was no comment concerning the state of the donor area in the charts of the other two.

COMPLICATIONS: Flexion deformity of 25 degrees to 50 degrees was noted at the operated hip in three of these four patients. In addition, two had abduction deformities, the degree not stated. There was no statement about hip deformity in the fourth one. Shortening of the affected extremity amounted from "a little" to more than five inches. Specific notes are found on only two of the records but it was noted that a third one required 5⅞ inch lift on the shoe. There is practically no information concerning back or knee complications in these four patients.

Summary and Conclusions

Sixteen patients having had ischiofemoral arthrodesis at Kosair Hospital during the period of 1946 through 1951 were studied. Thirteen had tuberculous arthritis of the hip, two had undiagnosed destructive arthritis and one had congenital dislocation of the hip. In eleven of the cases, Brittain procedures were done; in five, Trumble procedures were done. In one of the Trumble procedures, and in all of the Brittain procedures, autogenous bone was used for grafts. Because of the relatively higher incidence of failure of fusion in the cases using bank bone, it is felt that autogenous bone should be used for the graft in this type operation. Also, because of the higher incidence of failure in those patients under age eleven years, it is felt these procedures are better reserved for those patients beyond that age. No consistent correlation could be established between rate of success and 1) duration of disease, 2) sex, 3) duration of immobilization, 4) frequency of cast change, 5) use of antituberculous drugs, 6) presence of tuberculous lesions elsewhere in the body, or 7) previous surgery on the hip. Complications following surgery are discussed.

The Artificial Kidney*

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Historical Background

GOING back to 1914 we find this opening paragraph in the first published report on the artificial kidney.

> There are numerous toxic states in which the eliminating organs of the body, more especially the kidneys, are incapable of removing from the body at an adequate rate, the natural or unnatural substances whose accumulation is detrimental to life. In the hope of providing a substitute in such emergencies which might tide over a dangerous crisis, as well as for the important information which it might be expected to provide concerning substances normally present in the blood, and also for the light that might be thrown on intermediary stages of metabolism, a method has been devised by which the blood of a living animal may be submitted to dialysis outside the body and again returned to the natural circulation without exposure to the air, infection by microorganisms, or any alteration which might be prejudicial to life.

This statement of Abel, Roundtree, and Turner,[1] working in the Department of Pharmacology at the Johns Hopkins Medical School, summarizes the goal of the artificial kidney. Their apparatus consisted of collodion tubes which they formed themselves and which were tied to a system of branching glass tubes by string. To prevent coagulation they used hirudin, the active anticoagulant of the leech. This they obtained by decapitating leeches, grinding the heads in saline, and extracting hirudin from the solution. Diffusible substances from the blood passed through the semipermeable collodion membrane into a rinsing fluid of 0.6% saline. These authors concluded from their animal work that such substances as urea, glucose, phosphates, and aspirin could be removed by this method. Heat sterilization of the apparatus was impossible and so thymol was kept in the tubing between experiments.

Further mention of the artificial kidney is sparse in the medical literature until 1943, when heparin was readily available as an anticoagulant. Then Kolff, in the Netherlands, utilized a previous suggestion that commercially available cellophane sausage casing be used for the dialyzing semipermeable membrane. His machine consisted of 130 feet of cellophane tubing wound around a rotating drum and attached at both ends to fittings which led to a rotating coupling. Blood which entered this tubing from a cannulated artery was propelled by gravity and returned to a plastic reservoir by means of a pump. From the reservoir, blood flowed by gravity into the patient's cannulated vein.

Another type of hemodialyzing apparatus employs cellophane tubing or sheets compressed externally by a screen or metal grid. These tubes require considerable hydrostatic pressure to maintain blood flow but also permit the outflow of plasma water by ultrafiltration. The efficiency is further increased by a crosscurrent of circulating bath solution. This second type of hemodialyzer is exemplified by the units of Alwall, Murray, and Skeggs and Leonards, and the recent Kolff disposable coil kidney.

The bath fluid in all these types is the same, containing the essential electrolytes at concentrations found in an ultrafiltrate of normal plasma (Table 1). Enough glucose (or invert sugar) is added to increase the osmolar concentration and balance the effect of the nondiffusible plasma proteins.

General Principles

The basic principle of the artificial kidney is the semipermeable membrane, which may be compared to the capillary wall of the glomerulus. The membranes used are sheets or tubes of commercial cellophane, which in order to act as a dialyzing membrane must be grossly

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TABLE 1

Composition of Rinsing Fluid for the Artificial Kidney

Component	Gm./100 Liters	Milliequivalents per liter					
		Na^+	K^+	Ca^{++}	Mg^{++}	Cl^-	HCO_3^-
Sodium chloride	570	97	...	...	...	97	...
Sodium bicarbonate	300	36	...	...	...	...	36
Potassium chloride	40	...	5	...	...	5	...
Calcium chloride	28	...	...	5	...	5	...
Magnesium chloride 6 H_2O	30	...	...	...	3	3	...
Total		133	5	5	3	110	36

Invert sugar (Travert), 0.4%, and lactic acid to adjust pH to 7.4. During dialysis 10% CO_2 in O_2 is bubbled through to maintain pH. Sometimes 20 Gm. KCl (2.5 mEq. of K+) is used.

swollen with water. When this occurs channels of submicroscopic size are opened; it is the size of these which determine the size of the particles which pass through the membrane. This cellophane membrane must be sterilized, either chemically with Zephiran® or by boiling, steaming, or autoclaving. This laborious process, plus the sterilization of all other tubing which will carry the blood from the patient through the membrane and back to the patient again, has been simplified in the newer Kolff disposable coil kidney. In this apparatus the expendable equipment is available previously sterilized by Travenol, a subsidiary of Baxter Laboratories, Morton Grove, Illinois.

To review the principles of diffusion, we can imagine a vessel divided into two compartments, A and B. In compartment A is an aqueous solution, crystalloidal or colloidal, and in compartment B is pure water. Because of the concentration gradient across the membrane, water will tend to diffuse into the solution and the solutes into the water compartment. If the membrane pores are large as compared to the solute particles, both processes take place in a "free diffusion." If, however, the pore sizes are of the same order of magnitude as the solute particles, then the solute particles are impeded in their transfer across the membrane, although the transfer of water takes place freely. In a situation in which the membrane is impermeable to colloidal solutes but permeable to crystalloids, a differential diffusion occurs. This is known as dialysis and occurs with all types of artificial kidneys now commonly in use. An increase in hydrostatic pressure in "compartment A" with the ultrafiltration of plasma water is possible with such stationary dialyzers as that of Skeggs and Leonards and the newer Kolff coil kidney. It is not possible with the rotating drum type, but extra glucose can be added to the bath water to increase its osmotic pressure and thereby remove some edema fluid before the glucose establishes an equilibrium in the plasma.

Technical Problems

Clotting of blood is prevented by heparin, the use of polyvinyl plastic or silicone treated glass for tubing and connections, and the reduction of turbulent flow. The prevention of clotting adds the problem of hemorrhage. However, despite heparin and the hemorrhagic diathesis so common to uremia, dialysis has been employed on many patients with surgical and open wounds without a serious increase in local hemorrhage. Bleeding which cannot be easily seen or controlled, such as into the gastrointestinal tract, is still a hazard. Recently the technique of regional heparinization has been described, in which heparin is added to the arterial blood as it enters the machine, allowing protamine to drip into the returning venous blood. This may reduce the threat of uncontrollable internal hemorrhage in those patients in whom this danger exists.[2]

Hemolysis must occur to some degree in every case but can be reduced by the use of a smooth flow and "fresh" blood to prime the machine. If through error the temperature of the bath water became excessive or salt was omitted from the bath water, hemolysis could prove disastrous.

Blood volume changes may occur, and a small reduction of blood pressure is not unusual at the start of dialysis. However, with the machine properly "primed with blood" at the outset and the flow rate constant, these changes should be small and can be adjusted. When the blood flow through the artificial kidney is over 200 cc. a minute (which it usually is), hypertension is not uncommon. Some of this may be due to a demonstrated increase in cardiac output, but its entire mechanism is not clear. The use of a hypotensive agent such as pentolinium (Ansolysen®) may be needed or 300 cc. of blood may be removed.

It is quite common to see a further suppression of urinary output on the day of and the day following treatment with the artificial kidney. This is interesting but ordinarily of no clinical consequence because of its transient nature. Two explanations have been offered: (1) a temporary diminution of renal blood flow and (2) the sudden reduction in the amount of blood urea, which had acted as a diuretic agent.

Sterility has been a problem, especially with the older models, and some of the "pyrogen" reactions were undoubtedly bacteremic in origin. However, the cellophane is impermeable to such large particles as bacteria and viruses, and unless a leak is present no contamination should result from the unsterile bath tank and bath water.

A leak of blood from this machine is possible even after pretesting, especially when high ultrafiltration pressures are used. No danger is involved if an alert operator is watching the machine, since its use can be stopped in an instant. For this reason a doctor should be in constant attendance.

Technical problems which are easily glossed over but which in practice can be discouraging are the time needed in preparation of the machine, the necessity for procuring 2 to 3 pints of reasonably fresh blood to "prime" the machine and use for emergencies, the need for expert cannulation of a good sized artery and vein, and the period of six hours usually required before optimum results are obtained from the dialysis.

Experience With Its Use

My interest in the artificial kidney was acquired in 1953, when I was assigned to work with the renal insufficiency center in Wonju, Korea. This center was established during the Korean War in an attempt to reduce the mortality rate of those combat casualties (0.5 per cent of the total) who developed post-traumatic renal insufficiency. In a study of similar cases in the Italian theater during World War II, the mortality of those casualties having measured urinary output of less than 100 cc. during any 24 hour period was 91 per cent.[3] Early in the Korean War a group of nine such patients were reported on, with only one survival.[4] Including those patients with renal insufficiency and oliguria (less than 500 cc. per day) who were treated in such special centers, the mortality rate was 80-90 per cent. For this reason an artificial kidney was transported to the renal insufficiency center at Wonju. During the sixteen month experience of this center, about 160 patients were seen and the over-all mortality rate was reduced to about 55 per cent. Many of the milder cases, however, never required dialysis, and certain principles of medical management were again re-emphasized.

Patients with nontraumatic renal insufficiency did best. In fact, the group with uremia from hemorrhagic fever were found to do poorly if dialysis was done with the artificial kidney. It was also clearly evident that patients transported to the center in a hypotensive state did very poorly and that the diagnosis of renal insufficiency was not justified until the blood pressure had remained normal for several hours without infusions or stimulants. If at this point less than 20 cc. of urine in one hour was obtained from an indwelling catheter, the diagnosis of renal insufficiency was obvious and special management in order. This included (1) fluid restriction in the range of 500-600 cc. per 24 hours plus the measured output (700-800 cc. plus, if the weather was hot or the patient febrile), (2) a non-protein, high caloric intake, and (3) measures to combat hyperkalemia.

Pulmonary edema and secondary infection caused most of the deaths at the Wonju center. Dialysis is rarely indicated before the fifth day of oliguria or anuria, even for hyperkalemia,

if the patient is under good medical management. Hyperkalemia may be watched for with the electrocardiogram. It is true that other factors may modify the appearance of the EKG, but the EKG is quite accurate in assessing dangerous levels of hyperkalemia.[5]

Although dialysis by the artificial kidney is quickly effective in reducing dangerous levels of serum potassium (usually within 20 minutes), the hyperkalemia will soon return following dialysis if measures are not taken to combat it. The continuous intravenous administration of 20 per cent glucose and insulin (one unit of insulin for each 2 gm. of glucose) is of definite aid, and I have used small amounts of a supplementary tube feeding with the following formula for its protein-sparing effect: 400 gm. of glucose, 100 cc. of peanut oil, 25 gm. of acacia to emulsify, and water to make up one liter (2500 calories/liter). Practical considerations will usually limit the number of dialyses in a single patient to three or four.

Our experience in Lexington has been limited to the Kolff disposable coil kidney (Figure 1). As of this writing we have used this machine on ten occasions in about ten months' time. No accidents or deaths have occurred from its use, and there is no doubt as to its efficiency in improving the uremic and electrolytic picture in every patient. Since other factors are involved, it has not, of course, always proved lifesaving. A typical result of a dialysis is shown in Table 2. The data are from the records of a patient with acute renal "shut down" following an incompatible transfusion reaction. This patient is now well and shows no evidence of residual renal damage.

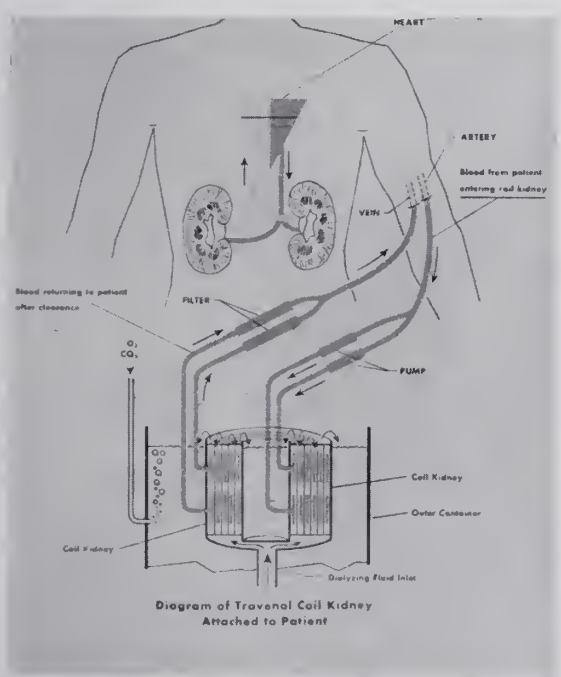


Figure 1. Diagram of Travenol Coil Kidney Attached to Patient.

TABLE 2

G. Mc. Results of 6 hr. Dialysis by Artificial Kidney

		Before	After
Urea	N	180 mgm.%	38 mgm.%
	K	5.5 meq/L	5.0 meq/L
	Na	134 meq/L	135 meq/L
	CO_2	14.8 meq/L	21.4 meq/L
Cell	Vol.	33 mm.	42 mm.

Indications

The disorders in which the artificial kidney may be useful can be divided into four groups:[6,7] (1) acute renal failure (2) chronic renal failure (3) presence of non-nephrotoxic poisons, and (4) intractible edema and overhydration.

To date acute renal failure has proved to be the most valid indication, since it is in this potentially reversible situation that the artificial kidney may prolong life and thereby prove to be lifesaving. Among the causes of such acute reversible anuria are (1) acute tubular necrosis ("lower nephron nephrosis") associated with an ischemic episode such as occurs in severe shock, hemolytic transfusion reactions, the crush syndrome, burns, and the hepatorenal syndrome; (2) nephrotoxic poisons such as mercury, carbon tetrachloride, phosphorus, and the sulfonamides; and (3) acute glomerulonephritis. However, the use of the artificial kidney in the early stages of acute glomerulonephritis has been followed by convulsions in several patients and is now avoided. The average duration of oliguria in acute renal failure is 10-12 days, but it can be much briefer or last as long as three weeks. When it is longer than this, other types of renal or urologic disease are usually found.

Chronic renal failure presents a less clearly defined indication for the artificial kidney, but there are three groups of patients who have been benefited: (1) The patients with asymptomatic renal insufficiency who develop an infection or manifest an acute exacerbation of their chronic uremia following surgery or some other stress. These may benefit particularly if a surgical procedure is performed to improve renal function—such as pyelotomy, prostatectomy, or the dilation of urethral or ureteral strictures. (2) Those with intractable uremic symptoms such as nausea and vomiting. Dialysis may retard the rapid clinical deterioration, though not usually for more than two to three months. (3) Those with chronic uremia needing some surgical procedure.

The artificial kidney can also be used to remove poisons from the blood which are not specifically nephrotoxic. Such toxins must not only be small enough to pass through the pores of the semi-permeable membrane but must be present to some extent in the circulating blood, unattached to plasma protein and tissue. Good results have been demonstrated in poisoning from salicylates, barbiturates, thiocyanates, and bromides. Unfortunately, the shorter-acting barbiturates such as secobarbital (Seconal®) do not dialyze well. The intermediate-acting barbiturates are better dialyzed (e.g. amobarbital [Amytal®]), and the best results are with phenobarbital, with which about 40% of the ingested dose may be recovered in the dialyzing fluid.[8] Because of the excellent results with conservative measures, some physicians limit dialysis to patients with a potentially fatal dose. In the case of phenobarbital this dose would approximate 5gm. and the blood level 8 mg. per 100 cc.

The fourth group benefited by hemodialysis are those patients with intractable edema and overhydration. With ultrafiltration in the newer Kolff disposable kidney and in the Skeggs-Leonards kidney, 1000 to 1200 cc. of fluid can be removed from a patient every hour. I have seen a patient, who was weighed immediately before and after dialysis, lose as much as nine pounds. This procedure has also been used in hepatic coma and diabetic acidosis, although these were specialized situations from which no general conclusions can be drawn.

Comment

It must be emphasized that the artificial kidney is only an adjunct to the standard therapy of uremia or anuria. Although it can be assembled for use within an hour or two, it is still complex and requires a trained team for good results.

Bleeding into the gastrointestinal tract or into the central nervous system is a contraindication to the use of the artificial kidney, but surface wounds and cut downs are not contraindications because such bleeding can usually be controlled with local pressure. Because of the increased cardiac output in some patients, a recent myocardial infarction is also a contraindication. There are no other major contraindications, although Merrill[9] would avoid the use of the artificial kidney in the early phase of acute glomerulonephritis, and most workers cannot see any rationale for its use in malignant hypertension.

Obviously, the artificial kidney still has research potentialities which have not been explored. What is the uremic substance (or substances) which dialyzes out in uremia and causes clinical improvement? We know it is not urea. Of what value is dialysis in hepatic coma and burns, and what metabolites are involved in these problems? Selective dialysis and the use of radioactive tracers are just a few of the problems which make the artificial kidney's role in research still an active one.

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Children's Hospital

Hugh B. Lynn, M.D., Surgeon in Chief, and Lawrence M. Linkner, M.D., Resident

CARCINOMA OF THE THYROID IN CHILDHOOD*

Present Illness

Z. G. M., birth date 7-23-44, a 14-year-old white female who was well until two months prior to admission, when her mother noted a small mass in the anterior neck region. The mass was asymptomatic, but for the past month she has occasionally experienced a sensation of suffocation. The mass is thought to have increased slightly in size. There has been no history of voice change, though, the patient complained of her voice "tiring" easily.

On 7-20-58 the patient was seen in the surgical clinic of the Children's Hospital because of the above complaints, and immediately admitted to the hospital.

Past History

The patient was first seen on 11-24-45 (age 16 months) because of a cystic mass on the left anterior neck. The description at that time was as follows: "This mass is easily depressed but feels as if it were filled with air. On the lower posterior portion of the cystic mass a firm nodular mass that is freely movable and about the size of a large pecan is felt. The total mass extends on the left side from the mandible to the clavicle and appears to enlarge when the child cries. The skin over the mass has a bluish tinge. No rigidity or thyroid enlargement is noted." This mass was noted soon after birth, of marble size, and did not change in size until one month prior to the first hospital admission at which time the mother noticed a rapid increase as described above. No other abnormality was noted on that admission.

On 1-15-46, surgical exploration of the neck was done and a partial removal of the cystic mass was done. Pathologic diagnosis was hemangioma. The patient was then transferred for deep x-ray therapy to the neck and mediastinum. The patient had a total of 600-R at that time. There was no other x-ray therapy and there were no other serious abnormalities noted prior to the present admission. Response to therapy was excellent and regression of the remaining tumor mass was noted.

Physical Examination

Patient is a thin, somewhat pale, 14-year-old white female in no distress. She is alert and cooperative, with satisfactory mental status. The entire physical examination is negative except for the neck region, which shows a firm nodule, approximately 1 cm. in diameter located on the anterior lateral aspect of the left pole of the thyroid. The nodule is not adherent to the skin, but moves on swallowing. The mass is non-tender and smooth, and there are scattered, freely movable, peri-tracheal nodes palpable bilaterally.

Hospital Course

The patient was prepared for surgery and the day after admission was taken to the operating room where excision of the nodule was done. Frozen section revealed carcinoma of the thyroid gland. Because of the patient's preadolescent status, it was decided to do a radical left sub-total thyroidectomy which included the left lobe, isthmus and lower pole on the right lobe, and await permanent sections to decide on therapy. Her postoperative course was uneventful and the final pathologic diagnosis was papillary adenocarcinoma of the thyroid gland, well differentiated, without evidence of vascular invasion. (Fig. 1) There were, however, two small lymph nodes showing papillary carcinoma and these nodes were found to be *external* to the capsule of the right lobe of the

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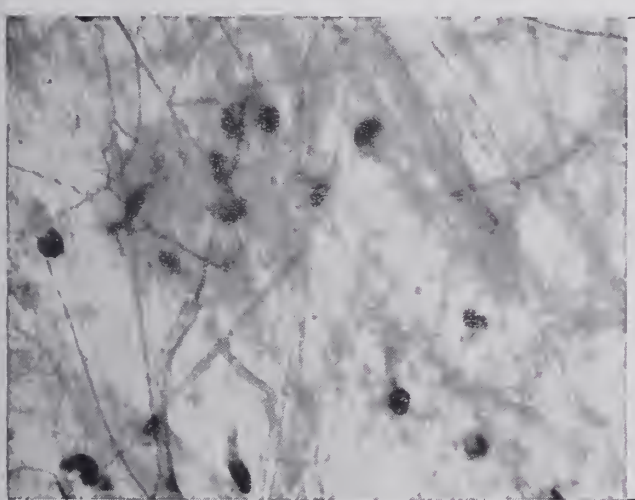
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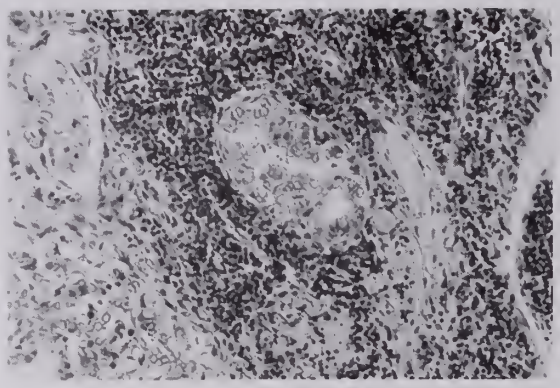


Figure 1. Adenocarcinoma of thyroid. The tumor is well differentiated and forms large and small acini, some containing colloid. Note the papillary excrescenses in the large acini. The cells are fairly uniform and only slightly irregular in arrangement. (X100)

thyroid gland. The patient was placed on thyroid extract, USP, 0.5 grains, b.i.d., later increased to 0.5 grains, t.i.d.

In view of obvious extension of the carcinoma beyond the limits of the thyroid gland, a bilateral neck dissection was elected as the best treatment for cure of the patient's disease. Ten days later, on 7-14-58, the remaining portion, right lobe, of the thyroid gland and a right radical neck dissection was performed. Recovery from this second surgical procedure was uneventful. The pathologic report following the radical neck dissection included 16 lymph nodes, and two of these showed invasion of the carcinoma. (Fig. 2) These nodes were located at the inferior pole of the right lateral lobe. There was no blood vessel or muscle invasion. The patient was discharged on the twentieth postoperative day on 0.5 grains, USP thyroid, t.i.d.

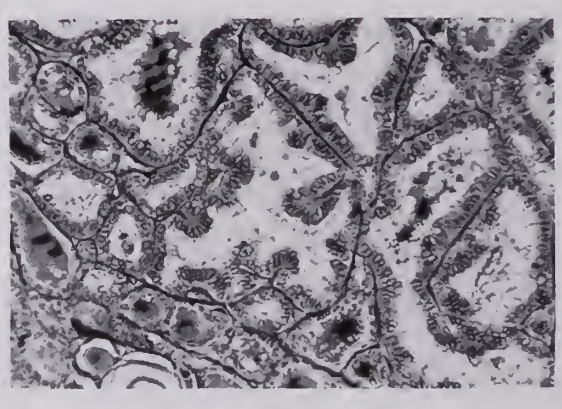


Figure 2. Lymph node showing metastatic tumor. The node is almost replaced; only a small amount of lymphoid stoma remains. (X40)

The patient was readmitted on 9-9-58, and on 9-11-58 a left radical neck dissection was carried out. The pathologic report showed that none of the 34 lymph nodes removed were involved. The patient's postoperative course was relatively uneventful except for facial edema. This edema slowly subsided prior to the patient's discharge but full resolution is not expected for three to six months. She was discharged nineteen days after admission, taking 2.5 grains of thyroid extract USP, daily.

Follow-Up

The patient was last seen on 12-23-58. Chest x-ray taken at this time was negative, as were all previous roentgenologic examinations of the lungs. She has gained five pounds since the last surgical procedure. The facial edema persists, but is gradually diminishing. (Fig. 3 and Fig. 4) She attends school daily and gives no evidence of hyper- or hypo-thyroidism. There has never been clinical or laboratory evidence of hypo-parathyroidism. The patient is being followed in the tumor clinic at the Children's Hospital.

Discussion

L. A. Davis, M.D., Department of Radiology: This patient received radiation therapy to the anterior superior mediastinum in 1946. Records from that time are incomplete, but apparently about 900 r. were administered. At the present time there is a definite relationship established between irradiation to the head, chest, or neck in infancy and the subsequent development of thyroid carcinoma. Approximately one-third of the children with thyroid carcinoma have been reported to have had irradiation.

Though an exact causal relationship is not certain, it would certainly seem wise to withhold such treatment in infants and children with benign conditions of the head, neck and chest.

W. W. Johnson, M.D., Department of Pediatric Surgery: The proper management of carcinoma of the thyroid in children is still a highly questionable matter since there are slightly less than 400 cases reported in the literature, and the majority of these have been reported in the last ten years. All have had varied treatment and considering this, and the relatively short term follow-up, it is felt that no definite conclusions can be drawn.

In this case had the radical lobectomy not been done the second lesion would not have





Figures 3 and 4. Postoperative appearance of the patient.

been found, since it was not palpable. Most authors agree that lobectomy is the treatment of choice in any carcinoma of the thyroid and that the cell type makes little difference in the therapy in children.

The chief point in controversy is the extent of further dissection necessary. This case had known nodes external to the capsule of the right lobe found by the pathologist after surgery. In light of the known multicentricity of papillary carcinoma, and due to the fact that the nodule in the right lobe was not palpable at the operating table, it was elected to remove the remainder of the right gland and do a neck dissection at this time. Further nodes on the right being found at this procedure, it was assumed that these either came from the palpable primary on the left or from the multicentric nodules on the right. With this possibility a left neck dissection was done.

It is our feeling that although papillary carcinoma is a relatively slow growing tumor it has much greater potential for a fatal outcome in children when vigorous surgical treatment is not undertaken.

Remember

Immunization Week

May 3-9



Guy Aud, M. D.

Guy Aud, M. D.

1887-1959

Francis Guy Aud, M.D., retired Louisville surgeon who was a past president of the KSMA and former editor of the Journal, died at St. Joseph Infirmary on February 27 at the age of 71.

President of the Association in 1947-48, he was President-Elect in 1946-47, and Vice President in 1945-46. Doctor Aud was president of the Jefferson County Medical Society in 1932. For many years he was chairman of the Advisory Committee to the Editor of the Journal of the KSMA and in September 1956 he was elected Journal editor, serving until July 31 of 1958 when his resignation for health reasons was reluctantly accepted by the Council.

Active in work of the American Cancer Society for many years, he served as president of that group in 1950. That same year, he was awarded a citation by the national society for "distinguished service in cancer control"—the first such honor presented to a Kentuckian. Besides serving as president of the national cancer group, he had been president and chairman of the executive committee of the cancer society's Kentucky Division. At one time he was regional director for 10 Southeastern states and Puerto Rico.

A native of Cecilia, Doctor Aud was the son of the late Charles Z. Aud, M.D., KSMA president in 1906. He graduated from the University of Louisville Medical Department in 1909 and began practicing in Louisville in 1915. He was in the Army Medical Corps from 1917 to 1919, leaving the service as a lieutenant colonel.

Doctor Aud is credited as being responsible for making Kentucky the first place in the world to have a "cancermobile" unit and for the installation by the State of the first cancer-clinic service in a Negro hospital in the nation. His work extended such service to all the State's institutional inmates.

The Kentucky State Medical Association, which he served for so long and so well, will particularly miss his wise counsel. His personal warmth and kindness, together with his intelligence, professional skill, experience, and philosophy of life, made Doctor Aud a person who was admired, emulated, and loved by his fellow man. His passing is indeed a great loss to his profession, his community, and his State.

EDITORIALS

A New Editorial Policy

RECENTLY the Editorial Advisory Board met to discuss various means by which the effectiveness and attractiveness of our Journal could be improved. Some minor items were recommended for immediate adoption and others will be referred to the Council for further consideration. Some change in our editorial policy was recommended and approved.

Heretofore we have limited contributions to the editorial page to 500 or 600 words. It was felt that a wider latitude for discussion of important topics should be allowed. This refers in particular to scientific editorials.

As frequently as practicable it is our hope to carry on these pages instructive scientific discussions in which the writer may summarize and condense the present accepted opinions on important themes of general interest. It is felt that this can be better accomplished to the general information of the reader if an article of more reasonable length is allowed. It is our thought that a bibliography need not be published with material used on the editorial page. It would be well however for the writer to prepare a list of his references so as to be better able to answer any enquiries that may be submitted to him.

This is our Journal. The editorial page is open to the membership of our society for the expression of opinion regarding any phase of life and activity, either professional or otherwise, that is of general interest and importance to our profession. We invite your contributions; more particularly those dealing with scientific subjects.

Sam A. Overstreet, M.D.

Sudden And Unexpected Death

EVERY sudden or unexpected death presents to some physician a problem in preparing a death certificate. The cause may be obvious and acceptable to all concerned. When this is not true the physician needs to be cautious lest the hasty assignment of a cause suggested by persons interested or by circumstances, may lead to gross error, dissatisfaction, or injustice, not to mention inaccuracies in our vital statistics. He has recourse to the coroner or medical examiner to whom may be given the responsibility of assigning a cause or who may require or perform a postmortem examination if indicated. All of us who practice medicine have no doubt erred at this point more often than we suspect. It is certain that, unless we have some familiarity with the person or circumstances concerned, we should not certify a cause of death without opportunity to see the body after demise and question those closely concerned.

A physician does not have to be a Sherlock Holmes or a specialist in forensic medicine in order to be reasonably observant and astute. The position of the body in relation to surroundings, evidences of violence or trauma, or strangulation; discoloration of the skin from carbon monoxide, cyanide or coal tar derivatives; or other circumstances, including the attitudes of those persons or relatives present may easily arouse suspicion that an official investigation or inquest should be conducted. People are generally informed regarding their liability for coroner's investigation in such

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

cases and are cooperative. Reluctance to do so may, within itself, lead to the conclusion that all is not well.

A tabulation by E. Lauren of 403 autopsies of sudden and unexpected deaths from natural causes indicates the following distribution of findings by systems—in adults—over 14 years of age. (72 per cent males, 28 per cent females): Heart and Aorta—51.0%; Respiratory System—12.0%; Brain and Meninges—15.0%; Digestive and Urogenital—9.0%; Miscellaneous—13.0%; Undetermined—0%.

In a review of 800 cases of sudden death in apparently healthy young soldiers from 1942-1952, 350 were due to heart disease, 91 to intracranial hemorrhage (of which 61 were due to ruptured aneurysms), 110 to meningococcemia and 249 to miscellaneous causes of which respiratory disease accounted for the largest number. After all causes had been tabulated as accurately as possible from complete autopsy findings, there remained 140 persons in whom there was not found one single change in the body which could be named as the plausible cause for death.

Since heart disease accounts for so large a percentage of sudden deaths in adults we are concerned with what are the mechanisms chiefly responsible. Dr. Samuel Oram F.R.C.P. states, "Disease of the Coronary tree is by far the most common and important cause of sudden, unexpected death. If an adult in perfect health suddenly falls dead, the chances are overwhelmingly in favor of coronary occulsion." But the suddenness of death is seldom explainable even by autopsy since the anatomical findings are not distinguishable from coronary occlusion in which the patient survived for weeks or even months. Diseases of the aortic valve, dissecting aneurysm, disturbances of rhythm, and effect of drugs on the heart are other leading causes of cardiac deaths.

Pulmonary thromboembolism is not unusually the immediate cause of sudden death, but is said to be exceedingly rare unless the patient has been inactive or bedridden for a period or has at least had the motion of an extremity restricted predisposing to the formation of phlebothrombosis.

Cerebral hemorrhage, with escape of 100 cc or more of blood into the cranial cavity within 24 hours or less usually results in sufficient rise in intracranial pressure to be incompatible with life. Aneurysms of the circle of Willis or its branches, arteriosclerosis, hypertension, or hemorrhage from brain or meningeal tumors form the most frequent basis of such hemorrhages. Dinning and Falconer have presented a review of 250 instances of death from ruptured cerebral aneurysms. Five per cent of these occurred below the age of 30 years. A correct diagnosis of subarachnoid hemorrhage had been made in only 17 of 250 cases or 7%. Rupture of intracranial aneurysms are estimated to account for 4% to 5% of all sudden and unexpected natural deaths.

Peripheral circulatory failure may occur rapidly and may result from almost any massive or overwhelming blood stream infection as pneumonia, poliomyelitis or meningococcemia (generally described as Waterhouse-Friderichsen syndrome), or diphtheria. Deaths from shock like effect (on the central nervous system) such as from staphylococcemia, carbon monoxide, cyanide, alcohol or barbiturates may be indistinguishable from the peripheral circulatory failure described. Death within a few hours may result from exsanguination without external appearance of hemorrhage. The two diseases most often responsible for rapid death from blood loss are erosion of gastric or duodenal ulcer into a larger artery or bleeding from esophageal varices. Cardiac tamponade from rupture of aortic aneurysm into the pericardium is very quickly and silently fatal. Rupture of systemic aneurysms elsewhere, bleeding from ectopic pregnancy, splenic rupture in disease (as opposed to trauma), placenta praevia, and even hemorrhage from pulmonary tuberculosis may prove fatal within a period of minutes or a few hours.

There is an interesting tabulation by Dr. George W. Thoma of instances of sickle cell anemia resulting in sudden death. Of 126 selected negro necropsies, sudden or unexpected death from subclinical sickle cell anemia without other disease occurred in 3 cases or 1.4%. In 8 other cases it was regarded as a principal contributing cause.

Acute pancreatic necrosis can cause sudden death. Five such cases are described by G. Williams and he cites the report of 10 other instances. The use of alcohol is regarded by him as an important, but not by any means the sole causation of pancreatic necrosis.

James Maxwell from the Royal Chest Hospital, London, tabulates nine instances of sudden death from asthma and states that "in each case the event was sudden and completely unexpected, within a few minutes of the onset of what appeared to be an average attack of asthma, and the only apparent explanation in each instance was a sudden failure of respiration." He believes such a termination of the disease is more likely among patients who develop asthma after the age of 35 years and who exhibit depressive tendencies.

We, as practicing physicians need to be most careful in assignment of cause of death, particularly where it has occurred suddenly and unexpectedly. If reasonable doubt appears we would do well to avail ourselves of the services of the coroner or medical examiner. Statistical information on the most probable cause of death under described circumstances is helpful, but may be misleading. More accurate and detailed enquiry into individual cases has enriched our literature on this subject in recent years and should stimulate the individual physician to be as precise and accurate as possible in the interest of all concerned.

Sam A. Overstreet, M.D.

Manuscript Memos

Maruscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

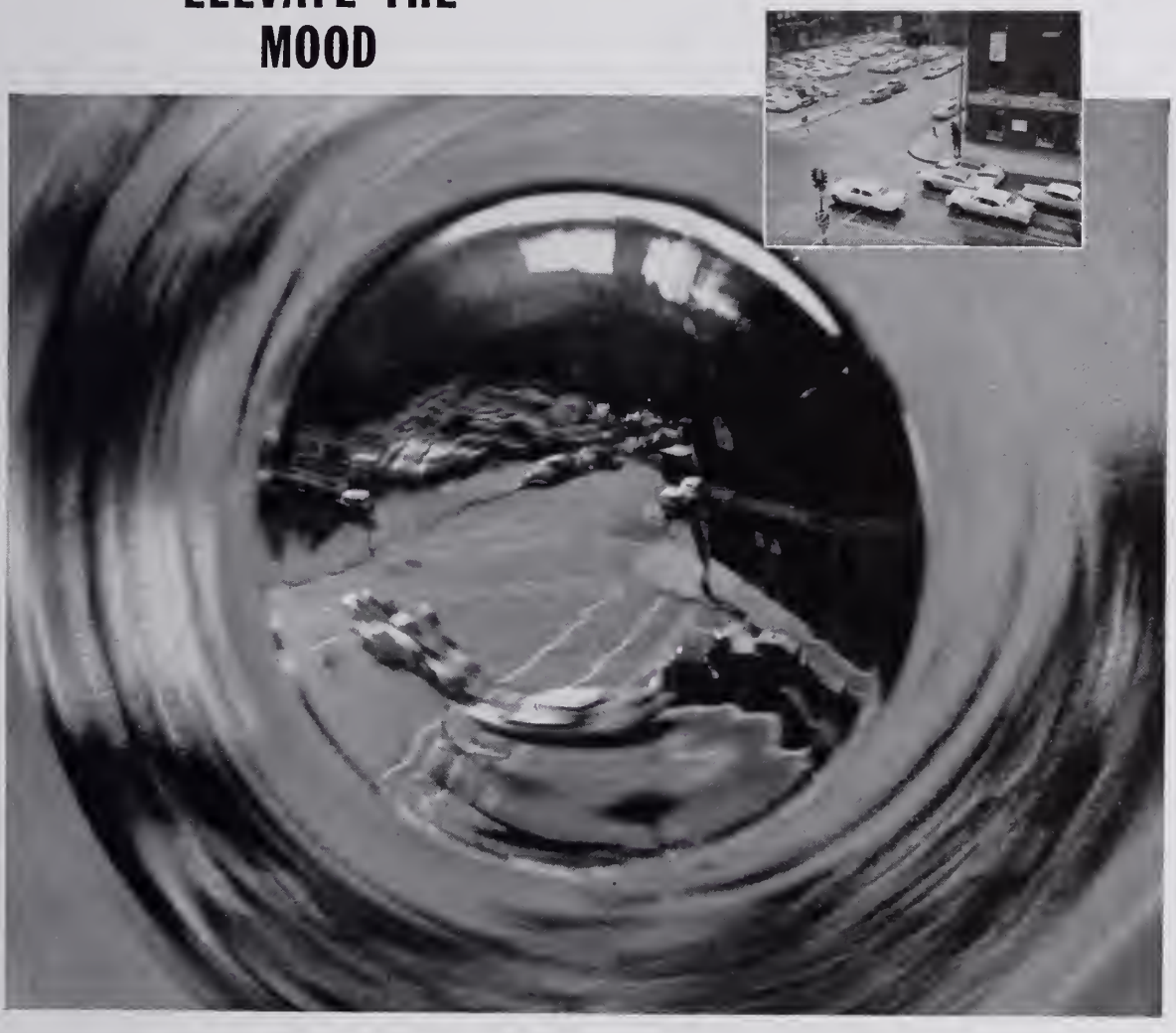
All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, The Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

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*Pratt, R. T. C., and McKenzie, W.: Anxiety States Following Vestibular Disorders, Lancet 2:347 (Aug. 16) 1958.

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ORGANIZATION SECTION

AMA Considers 3rd Party Matters at Atlantic City June 8-12

KSMA's two delegates to the AMA—Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville—will vote on two highly important questions relating to third party medicine at a meeting of the AMA House of Delegates during the AMA Annual Meeting in Atlantic City, N. J., on June 8-12.

Kentucky's view on the two questions was scheduled to be decided at a meeting of the KSMA House of Delegates in Lexington on March 26. The AMA House is to meet on the questions June 8.

The questions asked by the AMA are: "1. Free Choice of Physician—Acknowledging the importance of free choice of physician—Is this concept to be considered a fundamental principle, incontrovertible, unalterable, and essential to good medical care without qualifications? 2. Closed Panel Systems: What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?"

Other features of the five-day meeting will give physicians an opportunity to catch up on aspects of the rapidly-changing medical world.

This is the sixteenth time the meeting has been held in Atlantic City. Scientific exhibits, lectures, motion pictures, panel discussions, televised surgical procedures, scientific and technical exhibits will be featured at the meeting. The Woman's Auxiliary will hold its meeting Tuesday through Thursday. Other sidelights will be special art exhibits and the 43rd annual American Medical Golfing Association tournament.

Battle Against Polio Stressed During Immunization Week

The Kentucky State Medical Association, in cooperation with the State Department of Health will emphasize proper immunization against polio by the Salk vaccine during Immunization Week, May 3-9, it was announced by Delmas M. Clardy, M.D., chairman of the KSMA Committee on Public Health.

A special appeal will be made to all county societies by R. W. Robertson, M.D., president of the KSMA, asking them to please contact and work with civic organizations, local public health departments —and to ask each physician to be personally responsible for seeing that his patients and members of their families are properly immunized.

This will be the sixth year the KSMA has sponsored Immunization Week in Kentucky. Along with the drive on polio, immunization against tetanus, typhoid, diphtheria, whooping cough, and smallpox will also be featured.

Sixth District to Meet Jointly with TB Hosp. April 21

Featured speakers at the joint meeting of the KSMA's Sixth Councilor District and District Six State Tuberculosis Hospital in Glasgow on Tuesday, April 21, will be Michael L. Furcolow, M.D., Kansas City, and C. C. Howard, M.D., Glasgow.

Announcement of the meeting was made by John P. Glenn, M.D., Russellville, Sixth District Councilor. The meeting will begin with a dinner at 6:30 p.m.

Subjects to be discussed by Doctors Furcolow and Howard and full details of the meeting had not been received as the Journal went to press.

"Financing Health" Subject of 1st Dist. Meeting Apr. 22

"Financing Health" will be the topic discussed by Harry Hineman, Director, Actuarial Division, of Blue Cross and Blue Shield, Indianapolis, Ind., at a meeting of the KSMA's First Councilor District in Paducah on April 22.

Announcement of the meeting which will be held at Bosworth's Restaurant in Paducah was made by J. Vernon Pace, M.D., Paducah, Councilor for the First District.

Host group at the meeting will be the McCracken County Medical Society, of which Walker Turner, M.D., Paducah, is president. The dinner will start at 6:30, and will be preceded by a social hour at 5:30.

Surgical Groups Meet Jointly at French Lick in May

Program for the joint meeting of the Kentucky Surgical Society and the Kentucky and Indiana Chapters of the American College of Surgeons at the French Lick Sheraton, French Lick, Indiana, on May 15-16, has been announced by program chairmen Melvin Bernhard, M.D., and William T. Rumage, Jr., M.D., Louisville.

The meeting is entitled the Ephraim McDowell Memorial Meeting, honoring the 150th anniversary of the first ovariotomy which was performed by Doctor McDowell on Jane Todd Crawford in Danville in 1809. Francis M. Massie, M.D., Lexington,

will present a talk on some aspects of the Dr. McDowell story at the banquet session on Saturday night. Entertainment at the banquet session will be provided by John Mason Brown.

Wives of members are invited to attend the two-day meeting. Registration for the entire meeting is $10. Hotel reservations should be made directly with the French Lick Sheraton. Following is the program.

Friday Morning—9:30 a.m. to 1:00 p.m.

Ky. and Ind. Chapters, Am. College of Surgeons

PEDIATRIC SURGERY:

"Important Technical Features and Optimum Age for Surgery in Undescended Testicle," Robert Garrett, M.D., Indianapolis, Ind.

"Congenital Herniation of the Diaphragm in the Newborn," Merrill W. Schell, M.D., Owensboro

"Management of Mucosal Tear Encountered During the Course of Pyloromyotomy," Frank Scott, M.D., South Bend, Ind.

Hugh Lynn, M.D., Louisville, Ky. Discussant and Moderator

GENERAL SURGERY:

"Treatment of the Post-appendiceal Pelvic Abscess," Paul Hart, M.D., Evansville, Indiana

"Cortisone Therapy in the Face of Surgical Shock," George Sanders, M.D., Louisville, Ky.

"The Management of Squamous Cell Carcinoma of the Anterior Two-thirds of the Tongue," Condict Moore, M.D., Louisville, Ky.

J. R. Babcock, M.D., Danville, Pa., Moderator and Discussant

TRAUMATIC SURGERY:

"Mis-diagnosed and Overlooked Fractures," Frank Zeier, M.D., Evansville, Ind.

"Lacerations of the Liver Due to Blunt Trauma," Melvin Durkee, M.D., Evansville, Ind.

"Symptoms and Treatment of Non-penetrating Trauma to the Kidney," W. Vinson Pierce, M.D., Covington, Ky.

Arnold Griswold, M.D., Louisville, Moderator and Discussant

MANAGEMENT OF CARCINOMA OF THE CERVIX:

"Pathology," W. H. Christophersen, M.D., Louisville, Ky.

"Clinical Management," Laman Gray, M.D., Louisville, Ky.

"Radiological Management," Howard Dunham, M.D., Evansville, Ind.

Cyrus Erickson, M.D., Memphis, Tenn., Moderator and Discussant

PERIPHERAL VASCULAR SURGERY:

"Management of the Elderly Patient with Signs of Vascular Insufficiency in the Lower Extremities," J. D. McDonald, M.D., Evansville, Ind.

"Management of Embolism of Peripheral Arteries Seen in the First 24 Hours," David Hull, M.D., Lexington, Ky.

"The Differential Diagnosis of Raynaud's and Buerger's Disease," Alvin Ortner, M.D., Louisville, Ky.

Harold King, M.D., Indianapolis, Ind., Moderator and Discussant

Friday Evening—8:30 p.m. to 10:30 p.m.

Ky. and Ind. Chapters, Am. College of Surgeons

SURGICAL BACTERIOLOGY:

"Re-evaluation of the Methods of Cleaning the Hands of the Surgical Team," Ambrose C. Estes, M.D., Bloomington, Ind.

"The Management of Hemolytic Staphylococcus Aureus Infections," William T. Rumage, Jr., M.D., Louisville, Ky.

"Caps, Masks and Gowns; Who Should Wear Them and of What Material Should They be Made?" William R. Noe, M.D., Bedford, Ind.

John Reynolds, M.D., Chicago, Ill., Moderator and Discussant

ANESTHESIA AND SURGICAL PHYSIOLOGY:

"Prevention of Cardiac Arrest," John H. Combs, M.D., Evansville, Ind.

"The Use of Anti-emetics and Tranquilizers in the Surgical Patient," Douglas J. Giorgio, M.D., Evansville, Ind.

"Blood Transfusions in the Patient with One Kidney," L. Douglas Atherton, M.D., Louisville, Ky.

Eugene Connor, M.D., Louisville, Ky., Moderator and Discussant

PRE AND POST OPERATIVE CARE:

"When to Catheterize the Patient Who Fails to Void," Myron H. Nourse, M.D., Indianapolis, Ind.

"Complications of Gastric Intubation," Henry Collier, M.D., Louisville, Ky.

"The Management of Postoperative Hemorrhage Following Gastric Resection," James B. Holloway, M.D., Lexington, Ky.

Rudolph Noer, M.D., Louisville, Ky., Moderator and Discussant

SURGERY OF NEOPLASTIC DISEASE:

"Treatment of Recurrent Carcinoma of the Colon," Ben K. Harned, Jr., M.D., Evansville, Ind.

"Management of the Patient with Jaundice and Nodular Pancreatic Head," William C. ven dar Leith, M.D., Vincennes, Ind.

"Carcinoid Tumors of the Rectum," Allen Grimes, M.D., Lexington, Ky.

Henry Doubilet, M.D., New York, N. Y., Moderator and Discussant

Paul W. Hawley, M.D., director of the American College of Surgeons (subject to be announced)

Saturday Afternoon—1:30 to 4:00 p.m.

Kentucky Surgical Society

"Further Observations on Cholecystectomy," J. Duffy Hancock, M.D., Louisville, Ky.

"The Surgeon's Responsibility for the Surgical Specimen," James T. McClellan, M.D., Lexington, Ky.

"Duodenal Ulcer Treated by Vagotomy and Antral Resection," (Follow up of Over 600 Patients)," H. William Scott, Jr., M.D. Vanderbilt University

"An Attempt to Prevent Disruption of Abdominal Wounds," Malcom Thompson, M.D., and Blaine Lewis, M.D., Louisville

"The Effect of Major Surgery in Individuals with Healed Myocardial Infarction," Morris M. Weiss, M.D., Louisville

(Continued on page 468)



Your difficult rheumatic patient...

on the job again

through effective relief and rehabilitatio

For the patient who does not require steroids

PABALATE®

Reciprocally acting nonsteroid antirheumatics . . . more effective than salicylate alone.

In each enteric-coated tablet:

Sodium salicylate U.S.P.....0.3 Gm. (5 gr.)
Sodium para-aminobenzoate .....0.3 Gm. (5 gr.)
Ascorbic acid .....50.0 mg.

or for the patient who should avoid sodium

PABALATE® - Sodium Free

Pabalate, with sodium salts replaced by potassium salts.

In each enteric-coated tablet:

Potassium salicylate .....0.3 Gm. (5 gr.)
Potassium para-aminobenzoate .....0.3 Gm. (5 gr.)
Ascorbic acid .....50.0 mg.

For the patient who requires steroids

PABALATE®-HC

(PABALATE WITH HYDROCORTISONE)

Comprehensive synergistic combination of steroid and nonsteroid antirheumatics... full hormone effects on low hormone dosage . . . satisfactory remission of rheumatic symptoms in 85% of patients tested.

In each enteric-coated tablet:

Hydrocortisone (alcohol) ..... 2.5 mg.
Potassium salicylate ..... 0.3 Gm.
Potassium para-aminobenzoate.. 0.3 Gm.
Ascorbic acid .....50.0 mg.

PABALATE® Robins PABALATE®-HC

For steroid or non-steroid therapy: SAFE DEPENDABLE ECONOMICAL

A. H. ROBINS CO., INC. RICHMOND 20, VIRGINIA • Ethical Pharmaceuticals of Merit since 1878

2½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

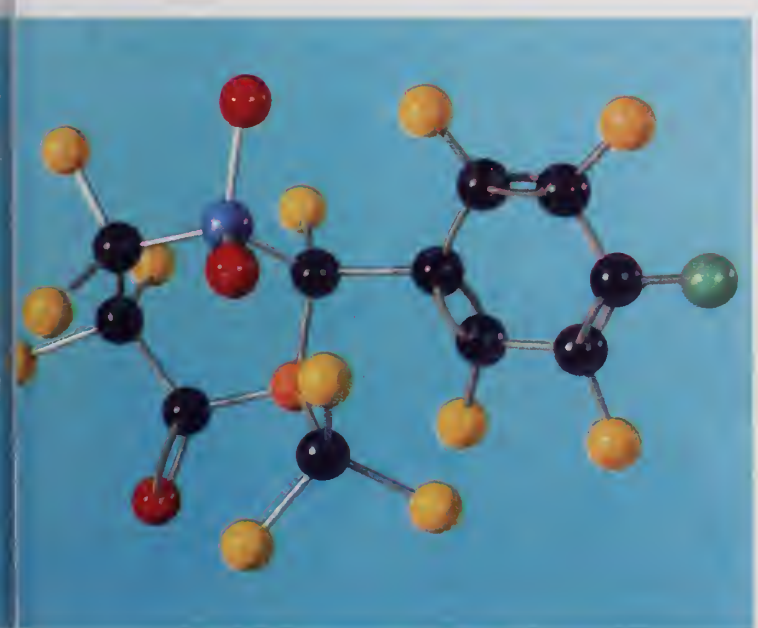
Trancopal®

*the first true tranquilaxant**

***Potent* MUSCLE RELAXANT**

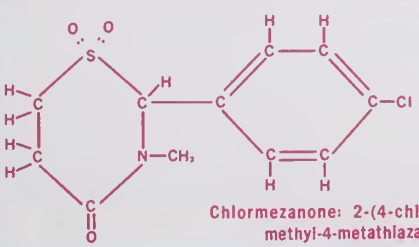
***... Equally effective as a* TRANQUILIZER**

*** tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in 91% of patients

INDICATIONS

Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias
Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

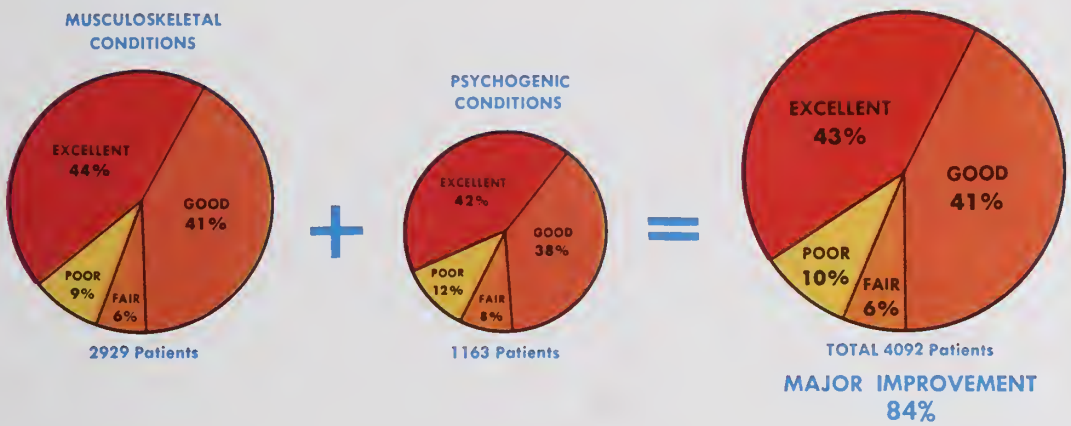
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "... allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



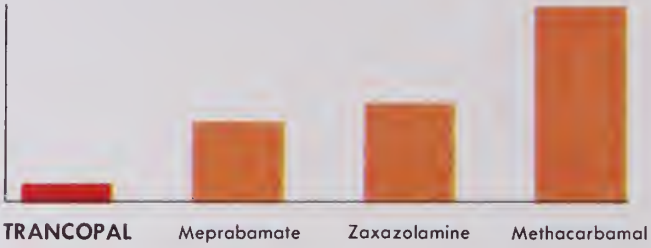
Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage.
Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

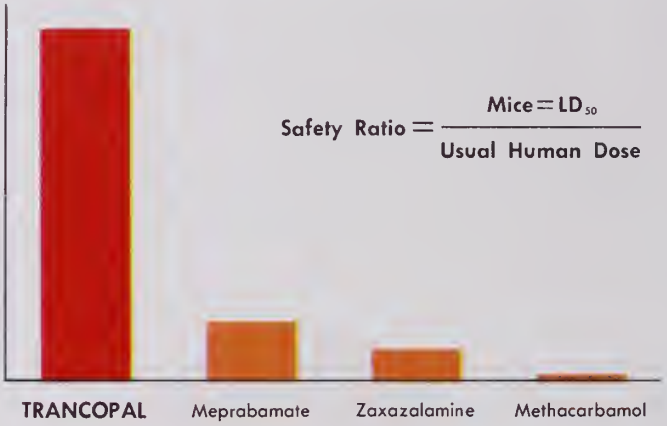
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness, Trancopal offers definite desirable advantages.



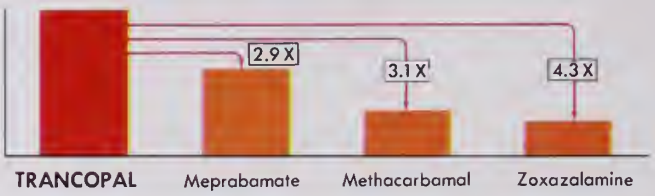
for activity

In the usual human dose, Trancopal is four to ten times as potent per milligram.



for safety

Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of the 40 patients received all four drugs in random rotation for several days. Although each of the four gave some relief, only the one providing the most effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. · 2. Gans, S.E.: To be published. · 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

Trancopal

Potent
MUSCLE RELAXANT
...Equally effective as a
TRANQUILIZER

Winthrop Laboratories / New York 18, New York

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MEMBERS MAY CONTINUE THEIR PROTECTION regardless of health.

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CREMOMYCIN®

SUCCINYLSULFATHIAZOLE—NEOMYCIN SUSPENSION WITH PECTIN & KAOLIN

EXPERIENCE

MORE THAN 16 MILLION DOSES ADMINISTERED WITH SAFETY AND EFFICACY.

regardless of etiology

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DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

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IN URTICARIA AND PRURITUS

VISTARIL*

HYDROXYZINE PAMOATE



A PSYCHOTHERAPEUTIC ANTIHISTAMINE

(as designated by A.M.A. Council on Drugs, 1958)

SPECIFIC ANTIHISTAMINIC ACTION in the treatment of a variety of skin disorders commonly seen in your practice.

"While some of the tranquilizers are only partially effective as far as antiallergic activities are concerned . . . [hydroxyzine] has been found, by comparison, to be the most potent thus far . . ."[1]

"The most striking results were seen in those patients with chronic urticaria of undetermined etiology."[2]

PLUS

PSYCHOTHERAPEUTIC POTENCY for the relief of anxiety and tension.

The psychotherapeutic effectiveness of hydroxyzine (VISTARIL) was confirmed in a series of 479 patients suffering from a wide variety of dermatoses, including atopic dermatitis, neurodermatitis, psoriasis, lichen planus, nummular eczema, dyshidrosis, pruritus ani and vulvae, and rosacea. "Adverse reactions were minimal."[3]

RECOMMENDED ORAL DOSAGE: *50 mg. q.i.d. initially; adjust according to individual response.*

VISTARIL Capsules: *25 mg., 50 mg., 100 mg.*

VISTARIL Parenteral Solution: *10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. hydroxyzine (as the HCl).*



REFERENCES:

1. Eisenberg, B. C.: Clinical Medicine *5*:897-904 (July) 1958.
2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958.
3. Robinson, H. M., et al.: So. Med. J. *50*:1282 (Oct.) 1957.

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"Two Hundred Selected Cases of Vaginal Hysterectomy and Anterior and Posterior Colporrhaphy with Complications and Technique Changes," W. O. Johnson, M.D., Louisville

Dr. Winters Addresses Seniors at Dinner March 16

Seniors at the University of Louisville School of Medicine were told that they were entering a profession which is "close to the heart beat of humanity" by Doctor Carl S. Winters, Oak Park, Illinois, one of the nation's foremost inspirational speakers, at the Senior Day banquet on March 16.

Telling them that they were one of the two professions on which humanity depends—the ministry of the healer, Doctor Winters also stressed the importance of our free enterprise system. He said, "No man ever knows what America is—until he has been where America isn't." By the same token, "You don't know what free enterprise in medicine is—until you get somewhere it isn't."

Doctor Winters' talk, "The Doctor's Glory Road," climaxed a series of addresses by 15 Kentucky physicians. His address was based on his experiences during world-wide tours and as former Crime Commissioner of Michigan and Chairman of the Skid Row Commission of Chicago.

Nathaniel L. Bosworth, M.D., Lexington, chairman of the KSMA Senior Day Committee, expressed appreciation for the cooperation of the Jefferson County Medical Society and the University of Louisville School of Medicine in making the day a success.

Family Doctor to be Chosen at Annual KAGP Meet

One of the highlights of the eighth annual assembly of the Kentucky Academy of General Practice at the Kentucky Hotel, Louisville, on April 22, 23, 24 will be the selection of the Family Doctor of the Year, according to Stuart M. Hunter, M.D., Louisville, program chairman.

Eleven nationally prominent scientific speakers will participate in the three-day program. Banquet speaker will be Joseph G. Molner, M.D., Detroit, well-known health columnist. The Thursday afternoon session of the meeting will include a luncheon and fashion show for the wives of members attending.

Members are urged to remember that this year's meeting will be held at the Kentucky Hotel for the first time in several years. Commenting on the change in meeting place, Doctor Hunter said the new facilities would eliminate the crowded conditions present in the past.

Louisville Site of '62 Meet

Louisville's Brown Hotel was chosen as headquarters for the 1962 meeting of the Southeastern Surgical Congress which will be held on March 12-15. Announcement of the choice was made by J. Duffy Hancock, M.D., Louisville, past councilor, who represented Clyde Sparks, M.D., Ashland, on the Council at the March, 1959 meeting of the Congress in Miami, Fla.

Kentuckians featured on the program of this year's meeting, which had a record attendance, were: Richard Hudson, M.D., and Robert Lich, Jr., M.D., of Louisville; and Charles Rutledge, M.D., of Hazard.



The future and what it holds for members of the graduating class of 1959 was discussed informally by this group following an address by R. W. Robertson, M.D., Paducah, president of the Kentucky State Medical Association. Pictured at Rankin Amphitheatre on Senior Day are—Nathaniel L. Bosworth, M.D., Lexington, Senior Day Chairman; Murray Kinsman, M.D., dean of the University of Louisville School of Medicine; Neville Caudill, president of the Student AMA; Lowell McClary, president of the Senior Class; Doctor Robertson; and Irvin Abell, Jr., M.D., Louisville, president-elect of the KSMA.

(Continued on page 474)

FROM BASIC RESEARCH–BASIC PROGRESS

HYDRODIURIL*

HYDROCHLOROTHIAZIDE

a new measure of activity



in edema

whenever there is need for diuresis

in hypertension

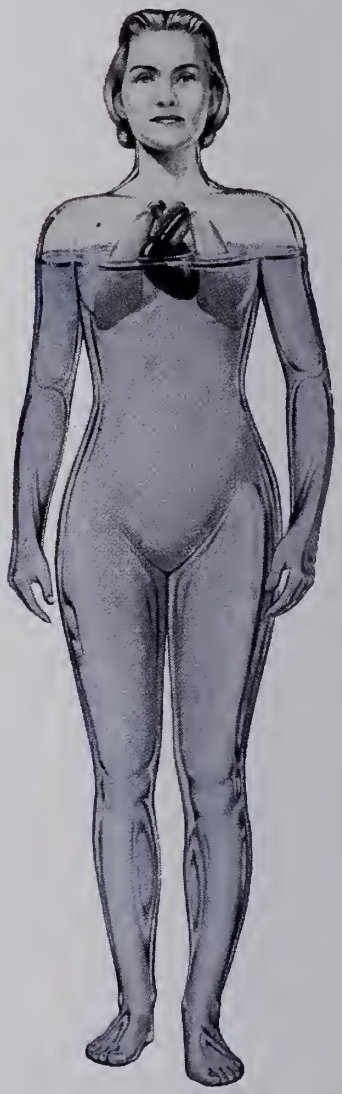
effective by itself in some patients—always as background medication in any antihypertensive regimen.

summary of clinical information—HYDRODIURIL (HYDROCHLOROTHIAZIDE)

IN EDEMA:

- greater oral effectiveness than with any other class of diuretic agent
- diuretic effectiveness maintained even on prolonged daily administration
- 25 mg. HYDRODIURIL orally is equivalent to 1.6 cc. meralluride I.M.
- has been reported to be effective even in patients who did not respond satisfactorily to other diuretics
- low toxicity—extremely well tolerated
- often achieves the benefits of a low salt diet without the unpleasant restrictions





HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- similar qualitatively to chlorothiazide but 10 to 12 times more potent
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

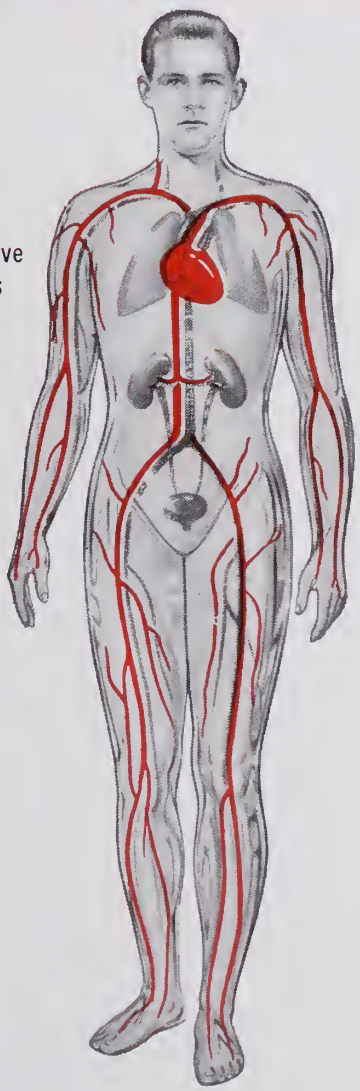
HYDROCHLOROTHIAZIDE

NEW RELEASE

IN HYPERTENSION:

- provides background therapy in any antihypertensive regimen (by itself, HYDRODIURIL adequately controls hypertension in some patients)
- has been reported by some investigators to have a greater antihypertensive effect in some patients than does chlorothiazide at equivalent dose levels
- does not lower blood pressure in normotensives
- markedly potentiates other antihypertensive agents
- reduces dosage requirements for other agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations





HYDRODIURIL*

NEW RELEASE

HYDROCHLOROTHIAZIDE





IS INDICATED IN:

1 Hypertension

2 Congestive heart failure of all degrees of severity

3 Premenstrual tension (edema)

4 Edema of pregnancy

5 Renal edema—nephrosis; nephritis

6 Cirrhosis with ascites

7 Drug-induced edema

8 as adjunctive therapy in the management of obesity complicated by edema

RECOMMENDED DOSAGE RANGE

In **EDEMA:** one to two 50 mg. tablets HYDRODIURIL once or twice a day

In **HYPERTENSION:** one or two 25 mg. tablets or one 50 mg. tablet HYDRODIURIL once or twice a day. (When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.)

SUPPLIED as 25 mg. and 50 mg. scored tablets, in bottles of 100 and 1000.

PRECAUTIONS:

It is important that dosage be adjusted as frequently as the needs of the individual patient demand.

HYDRODIURIL has shown no adverse effects on renal function and is essentially not nephrotoxic; for this reason it may be used with excellent results even in patients for whom organomercurials are contraindicated because of renal damage. The excretion of potassium is much lower than that of sodium and chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, this potassium loss may be easily replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

Additional information on HYDRODIURIL is available on request.

BIBLIOGRAPHY:

1. Esch, A.F., Wilson, I.M., Freis, E.D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959.
2. Ford, R.V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959.
3. Fuchs, M., Bodi, T., Irie, S., and Moyer, J.H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958.
4. Moyer, J.H., Fuchs, M., Irie, S., and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

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VERTIGO

VERTIGO

Each ANTIVERT *tablet contains:*

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.[2,3]

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics 2:110 (March) 1956. 2. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956.

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Science for the world's well-being



top left—Outlining the things to be covered in a panel on "Where You Practice" during the annual Senior Day are: Sam A. Overstreet, M.D., Louisville, Garnett J. Sweeney, M.D., Liberty; F. Hays Threlkel, M.D., Owensboro; and Carl Fortune, M.D., Lexington. Doctor Fortune moderated the panel.



top right—Enjoying the dinner at the evening session of Senior Day were: Dr. Carl S. Winters, Oak Park, Ill., featured speaker; Foster D. Coleman, M.D., president of the Jefferson County Medical Society, who presided at the dinner; and Robert W. Robertson, M.D., president of the KSMA.



bottom left—Two members on a panel which discussed "The Human Equation in Medicine"—Wyatt Norvell, M.D., New Castle, and David M. Cox, M.D., Louisville; are pictured with Senior Day Chairman, Nathaniel Bosworth, M.D., Lexington.



bottom right—Hostesses at a tea for wives and sweethearts of members were these members of the KSMA Woman's Auxiliary. (Left to right)—Mrs. Robert Monroe, Louisville; Mrs. Jesse Funk, Bowling Green; Mrs. Carlisle Morse, Louisville; Mrs. Murray Kinsman, Louisville; Mrs. Morgan Colbert, Louisville.

State Pediatric Group Meets in Louisville May 14

The Kentucky Chapter, American Academy of Pediatrics will hold a day-long meeting in Louisville on May 14, according to an announcement from Joseph Little, M.D., Louisville, program chairman.

The afternoon session will be held at Children's Hospital Amphitheatre and the evening session at the Medical Arts Building.

Following is the program:

Children's Hospital

3:00 p. m. *"Some Genetically Determined Biochemical Abnormalities of the Erythrocyte,"* Thomas Stevenson, M.D., assistant professor of medicine, University of Louisville School of Medicine

4:00 p. m. *"Evaluation of Laboratory Procedures in Pediatric Endocrinology,"* Beverly T. Towery, M.D., professor and chairman of the Department of Medicine, University of Louisville

5:00 p. m. Business Session

Medical Arts Building

6:30 p. m. Social Hour

8:00 p. m. Dinner

Conduct Fund Drive for Cancer During Month of April

The annual Cancer Crusade is being conducted during the first three weeks of April with the final house-to-house Crusade taking place on April 21. Slogan of the Crusade is "Fight Cancer with a Check Up and a Check."

"The medical profession obviously has a special interest in the cancer problem and the best ways of combatting it," said Houston Shaw, M.D., Louisville, chairman of the KSMA's Associate Committee on Cancer.

He urged all physicians to do their part to fight cancer by seeing that their patients are aware of the importance of a complete annual check up and by contributing financially to the Research and Educational Drive of the American Cancer Society. Physicians wishing to have pamphlets to distribute to their patients should contact the American Cancer

(Continued on page 479)

A workhorse "mycin" for common infections



respiratory infections

prompt, high blood levels

consistently reliable and reproducible blood levels

minimal adverse reactions

With well-tolerated CYCLAMYCIN, you will find it possible to control many common infections rapidly and to do so with remarkable freedom from untoward reactions. CYCLAMYCIN is indicated in numerous bacterial invasions of the respiratory system—lobar pneumonia, bronchopneumonia, tracheitis, bronchitis, and other acute infections. It has been proved effective against a wide range of organisms, such as pneumococci, H. influenzae, streptococci, and many strains of staphylococci, including some resistant to other "mycins." Supplied as Capsules, 125 and 250 mg., vials of 36; Oral Suspension, 125 mg. per 5-cc. teaspoonful, bottles of 2 fl. oz.

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Triacetyloleandomycin, Wyeth

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Wyeth®
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running noses and open stuffed noses orally



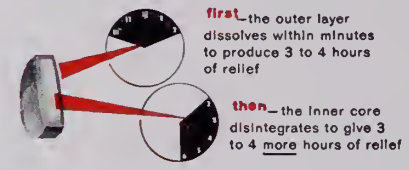
with TRIAMINIC, the oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication

- reaches *all* respiratory membranes systemically
- avoids "nose drop addiction"
- presents no problem of rebound congestion
- provides longer-lasting relief

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours.



Each* TRIAMINIC *Tablet provides:

Phenylpropanolamine HCl . . .	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and in the evening, if needed.

Triaminic®

Also available: For the occasional patient who requires only half dosage: timed-release TRIAMINIC JUVELETS. Each Juvelet is equivalent to ½ of a Triaminic Tablet.

For those patients who prefer liquid medication: TRIAMINIC SYRUP. Each 5 ml. tsp. of this palatable syrup is equivalent to ¼ of a Triaminic Tablet.

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re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE NOW SAYING ABOUT ATARAX®

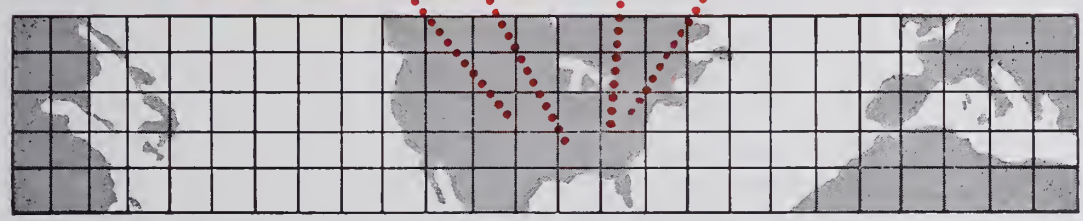
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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Dr. Robertson Announces Speaker for '59 Annual Meeting

Work on the program for the 1959 KSMA Annual Meeting is progressing well according to R. W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements who has released the name of one of the nationally known guest speakers who will headline the program.



Dr. Moore

Daniel C. Moore, M.D., Seattle, Wash., President of the American Society of Anesthesiologists, will be the guest of the Kentucky Chapter, American Society of Anesthesiologists, and will participate in a panel discussion during the general session.

A native of Cincinnati, Doctor Moore graduated from Northwestern University with an M.D. degree in 1944. He is a Diplomat of the American Board of Anesthesiologists, a past secretary of the section of anesthesiology of the American Medical Association, a past president of the Washington State Society of Anesthesiologists; and has held various offices in the American Society of Anesthesiologists. Doctor Moore is also the author of more than 40 papers and several books.

Dr. Denham to be Candidate for 65th Rep. District

Mitchell B. Denham, M.D., has announced his intention to run for the office of State Representative from the 65th Representative District, subject to the May 26th primary.

Doctor Denham is active in KSMA affairs and is currently chairman of the KSMA Committee on Rural Health and of Kentucky's Rural Health Council. KSMA President Robert W. Robertson, Paducah, commended Doctor Denham for his willingness to serve his state in this capacity.

A graduate of the University of Louisville School of Medicine in 1940, Doctor Denham is in general practice in Maysville and represents the ninth District on the Board of Directors of the Kentucky Chapter of the American Academy of General Practice.

Art Exhibit Held in McDowell Home

Fifteen students of the Centre College Wilderness Road Town Art Workshop showed their work at an art exhibit at the McDowell Home in Danville on March 13, 14, and 15. Mrs. Walker Owens, Mt. Vernon, was in charge of over-all arrangements for the three-day event.

Four M. D.'s to Speak May 14 at Joint Meet

"What Government Gives—It Can Take Away" is the topic of the talk which KSMA President Robert W. Robertson, M.D., will give at the dinner meeting of the 12th and 15th KSMA Councilor Districts at Cumberland Falls on May 14.

Scientific portion of the program in the afternoon will include three Louisville physicians. Sam A. Overstreet, M.D., will have as his topic, "Chronic Cholecystitis"; John Harter, M.D., will speak on "Lesions of the Esophagus"; and Oscar Hayes, M.D., will discuss "Fibroids and Pregnancy."

Announcement of the meeting was made jointly by District Councilors Garnett J. Sweeney, M.D., and Keith P. Smith, Corbin, for the 12th and 15th Districts, respectively.

Wives of the members are urged to attend, the announcement by the Councilors stated. Special activity has been planned for them.

U. L. Medical Instructor Wins $30,000 Markle Grant

Arthur C. White, M.D., an instructor in medicine at the University of Louisville School of Medicine, is one of 25 physicians, teachers, and research workers throughout the nation to receive a scholarship from the John and Mary R. Markle Foundation this year.

Doctor White's scholarship is for $30,000 over a five-year period. A native of Williamsburg, Doctor White graduated from Harvard University Medical School in 1952 and came to Louisville last fall from Vanderbilt University, Nashville, where he took his internship, residency, and held a fellowship. The Markle Award, made officially to the medical school, will further his teaching and research work in infectious diseases. He is studying staphylococcal disease.

Two other U of L faculty members have been Markle Scholarship recipients. They are: Frank Falkner, M.D., assistant professor of child health, in 1957, and Beverly T. Towery, M.D., chairman of the department of medicine in 1948 when he was at Vanderbilt.

Ky. Psychiatric Association Meets April 22

Richard H. Williams, Ph.D., acting chief of professional services of the National Institute of Health, will be the speaker at the Spring meeting of the Kentucky Psychiatric Association at the Phoenix Hotel in Lexington on April 22.

Announcement of the meeting was made by Logan Gragg, M.D., Eastern State Hospital, Lexington, who is Association president. Doctor Williams' topic had not been announced as the Journal went to press.

The meeting is scheduled to start with a social hour at 6:30, followed by dinner and Doctor Williams talk. Reservations may be made by contacting Irving Gail, M.D., in Lexington.

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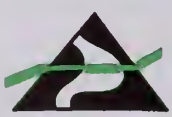
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Student leaders—Neville Caudill, president of the Student AMA, and Lowell McClary, president of the U of L Medical School Senior Class—ask Carl Cooper, Jr., M.D., Bedford, questions on the problems of setting up a practice.

STUDENT AMA

"What'll Become of The U. of L. Medical School?"

Recently, at one of the fishing docks on Cumberland Lake, the following question was posed by one of the local residents, 'Say, Doc, what do you think will become of the Louisville medical school when they open the one at Lexington?" Similar queries have been put to most of the medical students from people in all walks of life from all parts of the state. There seems to be a great deal of interest among the people of the state concerning the reaction of the University of Louisville to the impending opening of the University of Kentucky's Medical School—and certainly this interest, or curiosity, is justified.

It is impossible to say exactly what the effect will be on either school when the U. of K. opens its doors to medical students in 1960, but there are certain factors, already in operation, which will bear directly and significantly on the ultimate fate of the U. of L. Medical School. Assuredly the University of Louisville has come to a crossroads insofar as its medical school is concerned, and the question is consistently raised, "Can the U. of L. compete successfully for Kentucky students with the state-supported (*ergo,* infinitely richer) school at Lexington?" The mark of a great man is the ability to face reality in times of difficulty and to choose in these times a prudent course of action; this must also be true of a school. Whether the U. of L. has actually made any concrete plans in this context is not known to this reporter, and if they have been made their success remains to be seen, but in the past four years there have been developments in the school and city which indicate (to the writer, at least) that something is definitely being done.

In the past few years, but particularly in the last four years, there has been a remarkable increase in the number of new men on the full-time faculty. These men are, for the most part, young and enthusiastic teachers. This is true in both the preclinical and clinical faculties. In particular, the department of medicine has undergone striking change, not only with regard to personnel, but in the revitalized approach to teaching—undergraduate and graduate.

There has been a new emphasis placed on student research as evidenced by a program allowing the research-minded student to devote two months of his senior year to investigation under the direction of a qualified faculty member. The construction of a new research-building (to start this summer) is indicative of the further emphasis placed on graduate research. This building will also serve the purpose of alleviating crowded conditions in the school building and General Hospital, thereby improving the learning facilities available to the students in general.

As much as the students may dislike it, there is evidence that the academic standards are being raised. More students are being placed on probation, the work requirements seem more stringent, and compulsory national board exams are being planned so that the school may better evaluate its standing in regard to the national medical community.

Probably the most significant change, however, is the increasing awareness in the community of the value and importance of its medical school. A foundation has been formed among local business and professional leaders the sole function of which is to aid the medical school in its projects and problems. The city is facilitating, in every way possible, the continued growth of the Medical Center which will ultimately be a self-contained community of hospitals, schools, research facilities, and ancillary organizations, providing one of the best such educational centers in the country.

It may have been that all of these things would have come to pass without the impetus of the state medical school but it seems to this observer that the process has been greatly accelerated by the realization that this school cannot compete in terms of tuition with a state school but must compete in terms of excellence of educational opportunity and quality.

It is for this reason that many of us who were previously die hard "anti-second-medical-school-in-Kentucky-ists" have come to realize that with competition comes progress, and with progress comes better medical training. Most of us believe that if the school progresses in its present course and continues to raise its standards of achievement and performance, it has nothing to fear from competition; rather, the competition should be its most staunch ally.

So, what *will* happen to the U. of L. Medical School? No one can say for sure, but we hope that it will prosper and advance as never before.

W. Nevill Caudill, President
U. of L. Chapter, SAMA

Illinois University Offers Course

A course in laryngology and bronchoesophagology will be offered by the University of Illinois Department of Otolaryngology under the chairmanship of Paul H. Holinger, M.D., on November 9-21. Interested physicians should write directly to: Dept. of Otolaryngology, 1853 West Polk St., Chicago 12, Ill.



Members of the senior class and their physician "advisors" paused for coffee during the Senior Day activities on March 16.

Dists. 1 and 3 Plan Session at Ky. Dam Village

Three Louisville physicians will present the scientific portion of the program at the joint meeting of the First and Third Councilor Districts at Kentucky Dam Village on May 28, acording to J. Vernon Pace, M.D., Paducah, and Ralph D. Lynn, M.D., Elkton, Councilors for the 1st and 3rd Districts, respectively.

Featured after-dinner speaker will be Robert W. Robertson, M.D., Paducah, KSMA president. The scientific presentations will be given during the afternoon.

Participants in the afternoon program include: Marion Beard, M.D., who will speak on "Vitamin B-12 in Diagnosis and Treatment"; George Sanders, M.D., whose subject will be "Thyroid Cancer"; and Kenneth Crawford, M.D., who will talk on the "Current Status of the Staphyloccocal Problem."

Locked Wards for TB Patients Set Up at Hazlewood

An 18-bed unit has been opened at Hazlewood Sanitorium in Louisville as a locked-ward set up for tuberculosis patients who refuse voluntary treatment and spread the disease. The locked unit at Hazlewood, one of six state TB hospitals, will serve the entire state.

Joseph H. Humpert, M.D., South Fort Mitchell, chairman of the KSMA Committee on Tuberculosis, applauded the action as a step forward in the control of tuberculosis. The unit is operated by the State Tuberculosis Hospital Commission by agreement with the State Department of Health. Kentucky has a law which allows confinement of persons who do not take care to prevent spreading TB. The law says locked facilities may be set up or contracted for by the State Health Department.

Student AMA Meet in Chicago Starts April 30

Scientific papers and exhibits by more than a score of interns, students, and residents and presentations by leaders in medicine, including, Alton E. Ochsner, M.D., New Orleans, will highlight the ninth annual convention of the Student American Medical Association on April 30—May 3 at the Sheraton Hotel in Chicago.

Representing the Student AMA Chapter of the University of Louisville School of Medicine will be delegate Robert McKechnie, and alternate, William Collis. Others slated to attend as the Journal went to press were: Olson Huff, Gordon Gutmann, James Smith, Charles Gross, and Barney Elliott.

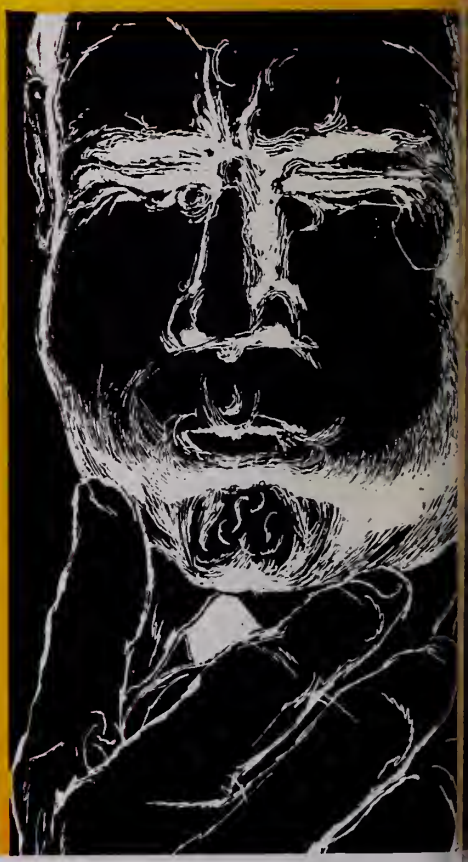
The delegate and the alternate delegate will attend the meeting of the Association's House of Delegates on April 30 and May 3 where official business and policy declarations will be made.

The co-author of "The Three Faces of Eve," Georgia psychiatrist, Corbett H. Thigpen, M.D., will be another speaker. His subject will be "Multiple Personality." The Woman's Auxiliary to the SAMA will hold its second annual meeting concurrently in the same hotel.

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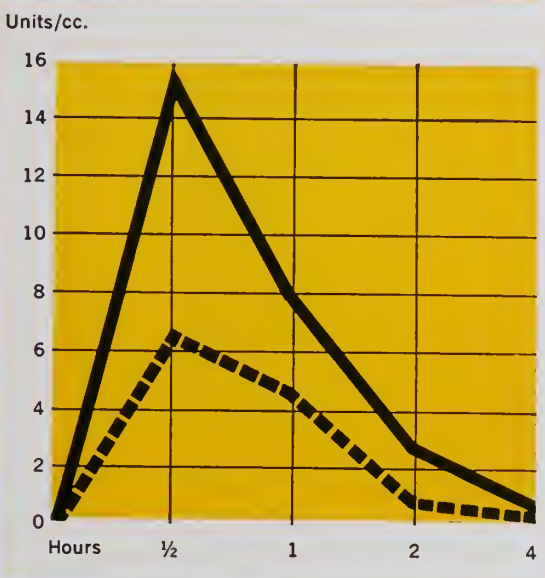
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Dr. Chu on "This Is Your Life" on March 18

Caleb H. Y. Chu, a Chinese physician who is one of two doctors on the staff of Oneida Mountain Hospital, Oneida, was the subject of the "This Is Your Life" program on television on March 18.

Doctor Chu does the surgery at the Seventh Day Adventist Hospital in Oneida and also is in general practice. A former houseboy of General Chiang Kai-shek in China, Doctor Chu was put through medical school by the couple in his country, and was graduated in 1942.

His wife, who is also Chinese, is an anesthetist and assists him in his operations. Doctor Chu first started practice in northwest China, near Communist territory and left the country shortly before the Communists took over control. He was at the Madison Tennessee Hospital when he first came to this country and was in Booneville before going to Oneida.

Dr. Orr Speaks in Kansas at Rural Health Conf.

Louis M. Orr, M.D., Orlando, Florida, president-elect of the American Medical Association, was a featured speaker at the 14th National Conference on Rural Health in Wichita, Kansas, March 5-7, which was attended by 600 physicians, public health nurses, farm organization representatives and farm leaders.

Blizzard conditions and zero visibility throughout Kansas which halted traffic completely at times, cut down the expected attendance. Three Kentuckians—Mitchell Denham, M.D., Maysville, chairman of the KSMA Rural Health Committee and Kentucky's Rural Health Council; Mrs. J. R. Winfrey, Burkesville, of the Kentucky Farm Bureau; and William E. Rudd, Louisville, of the KSMA Headquarters Office—attended the meeting.

The three-day conference was sponsored by the American Medical Association Council on Rural Health. Subjects covered included: mental health, aging, nutrition, dental health, costs of medical care and health insurance.

Heart Meeting Attended by 200

About 200 physicians attended the fifth annual Symposium on Cardiovascular Diseases sponsored by the Heart Association of Louisville and Jefferson County and the University of Louisville School of Medicine at the Brown Hotel in Louisville on March 11-12.

George W. Pedigo, Jr., M.D., was program chairman of the meeting which had a faculty of 13 prominent in the field of cardiovascular diseases. Dinner speaker was A. Carlton Ernstene, M.D., president of the American Heart Association.

State, Dental School Get Grants

Two recent federal grants totalling $164,500 will increase research done by the State Health Department and the University of Louisville Dental School. The State Department received $100,000 and the U of L got $64,500 for dental research.

Both grants are for building purposes—the Health Department's new $4 million headquarters in Frankfort and the $2,800,000 research building proposed as part of Louisville's medical center—but the increased space and improved facilities will enable more research, according to Russell Teague, M.D., Commissioner of Health, and William J. McGlothlin, U of L Vice President.

Senior Medical Students Guests of Ky. Blue Cross-Shield

Members of the Senior Class at the University of Louisville School of Medicine were guests of Kentucky Blue Cross-Blue Shield at a luncheon on Friday, March 20.

Following the luncheon, D. Lane Tynes, president of Kentucky Blue Cross and executive director of Kentucky Physicians Mutual, welcomed the seniors and explained the philosophy and history of the Plans. Sam A. Overstreet, M.D., chairman of the KSMA Advisory Committee to Blue Cross, spoke on the relationship of the medical profession to Blue Shield and the responsibilities of the future.

The seniors were taken on a tour of the new building to familiarize them with the internal functions of the plans.

Women M. D.'s Plan April Meeting in Louisville, Apr. 22

All women physicians in the state are invited to attend the semi-annual meeting of the Kentucky Chapter (Branch 49) of the American Medical Women's Association at the River Road Country Club in Louisville on April 22, according to Peggy Howard, M.D., Louisville, president.

The meeting, which is being held in conjunction with the KAGP meeting, will be held at 12 noon. Guest speaker will be Katharine Dodd, M.D., distinguished professor of pediatrics at the University of Louisville School of Medicine.

Luncheon reservations should be made several days in advance with Letitia S. Kimsey, M.D., 101 W. Chestnut, Louisville. The River Road Country Club is located about 5 miles from downtown Louisville. Transportation will be provided if needed. Those desiring it should telephone or write Peggy Howard, M.D., Brown Building, Louisville.

TB Commission Reports on Work in Hospitals During Year

Progress made in the treatment of tubercular patients in Kentucky is outlined in the Annual Report of the State Tuberculosis Hospital Commission to Governor A. B. Chandler.

The 33-page report, giving a narrative and statistical description of developments in the administration of Kentucky's six TB hospitals for the year ending June 30, 1958, is signed by C. C. Howard, M.D., Glasgow, chairman of the Commission, and Thomas M. Layton, executive director of the Commission.

Other physician members of the Commission are: V. A. Jackson, MD., Clinton; Alec Spencer, M.D.,

West Liberty, and Russell E. Teague, M.D., Louisville. The State tuberculosis hospitals are in Madisonville, Louisville, Paris, Ashland, London, and Glasgow.

Conference on Med. Ed. Held

Representatives of Kentucky's two medical schools spoke at a conference on pre-medical education and medical college admissions in Lexington on March 13-14 which was attended by about 80 college administrators and student advisors. Program was coordinated by William J. Hockaday, M.D., director of admissions, School of Medicine, University of Louisville, and Robert Straus, chairman, Committee on Medical College Admissions, University of Kentucky.

Speaking at a dinner meeting on Friday night, Dean Murray J. Kinsman, M.D., of the U of L, stressed the need for mutual assistance and cooperation between the two schools. Dean William R. Willard, M.D., of the U of K, said one of the most urgent purposes of the new U of K Medical Center is to meet the needs of the small towns and rural areas of the state.

Nurse Scholarship Fund Set Up

A nursing scholarship loan fund for girls who wish to enter the nursing profession and agree to work at least one year in a Paris hospital, was started recently by the Woman's Hospital Auxiliary of Bourbon County, according to an announcement from Mrs. Raymond Turner, president of the Auxiliary.

The scholarship loan recipients will be chosen by a special scholarship committee. Mrs. Turner said that the Auxiliary contemplates the sending of one girl to school each year in this way. Under this plan, the local hospitals would receive one new graduate nurse each year as soon as the first student graduates three years from now.

Dr. Conran Heads Western State

Harold William Conran, M.D., has been appointed Superintendent of Western State Hospital, Hopkinsville, to succeed R. G. Blackwelder, M.D., who died in February, according to an announcement from H. L. McPheeters, M.D., Kentucky Mental Health Commissioner.

A native of Canada, Doctor Conran has been Director of Professional Services for the Department of Mental Health in Louisville since last August. From 1957-58 he was on the staff of Central State Hospital, Lakeland, as Chief of Medical Services.

Otolaryngologic Meet Sept. 18-26

The Department of Otolaryngology of the University of Illinois College of Medicine has announced that it will hold its annual Otolaryngologic Assembly from September 18-26. It will consist of a series of lectures and panels concerning advancements in otolaryngology, according to Francis L. Lederer, M.D., professor and head of the Department of Laryngology.

Med. Ed. Conf. Set for Chicago

Prominent medical leaders met recently in Chicago to discuss plans for the Second World Conference on Medical Education which will be held in Chicago from August 29 to September 4, according to Louis H. Bauer, M.D., secretary general of the World Medical Association.

Sponsoring the Conference with the WMA are the World Health Organization, the Council for International Organizations of Medical Sciences, and the International Association of Universities. President Eisenhower is patron of the Conference.

Additions to KSMA Roster Listed

Recent additions to the KSMA membership roster include:

Charles O. Bruce, M.D., Louisville
H. J. Cowherd, M.D., Frankfort
M. J. Cawein, M.D., Lexington
D. P. Penn, M.D., Lexington
John W. Ragsdale, Jr., M.D., Fulton
Lewis R. Sutton, M.D., Elkton
J. N. Tulloh, M.D., Central City
J. H. Turner, M.D., Hopkinsville
Margaret B. Vermillion, M.D., Louisville
Robert Wheeler, M.D., Georgetown
Lloyd G. Yopp, M.D., Louisville

Scout-O-Rama is April 10-11

KSMA members interested in Scout work will be particularly interested in attending Scout-O-Rama, the showcase of Scouting, which will be held in the West Wing of the Fairgrounds Exposition Center in Louisville on April 10-11.



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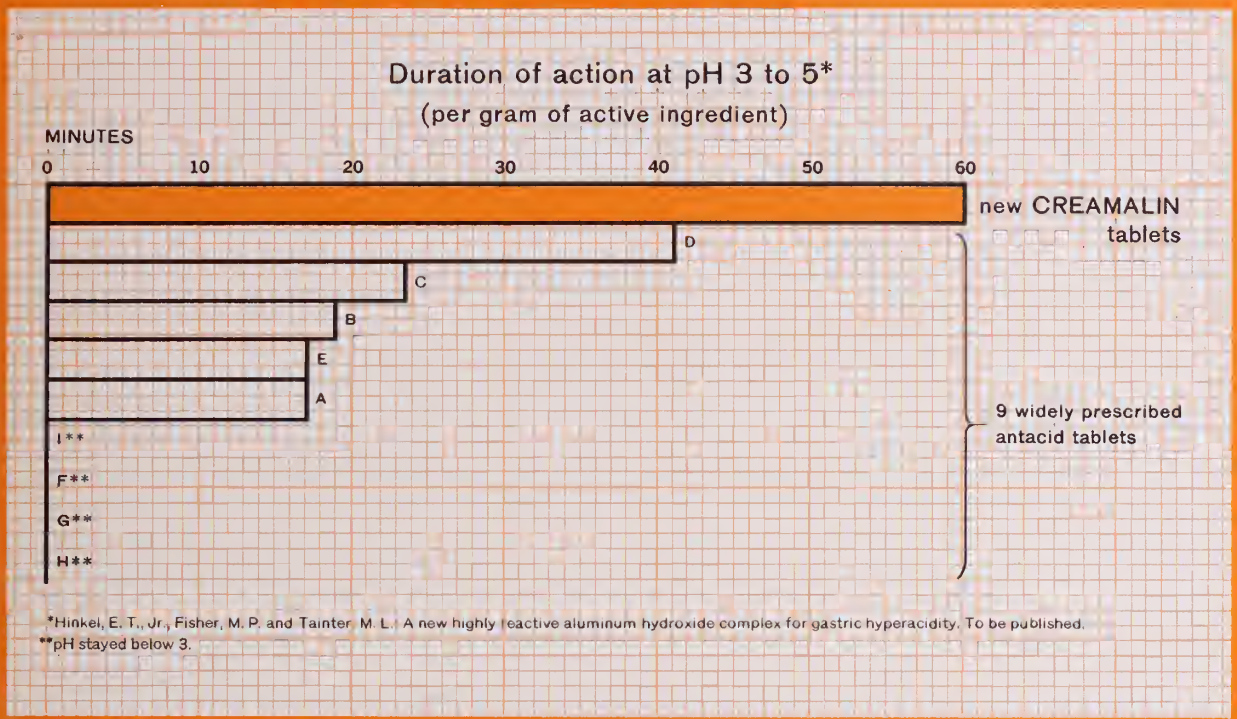
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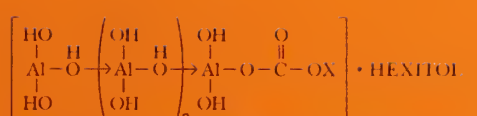
*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L. A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.



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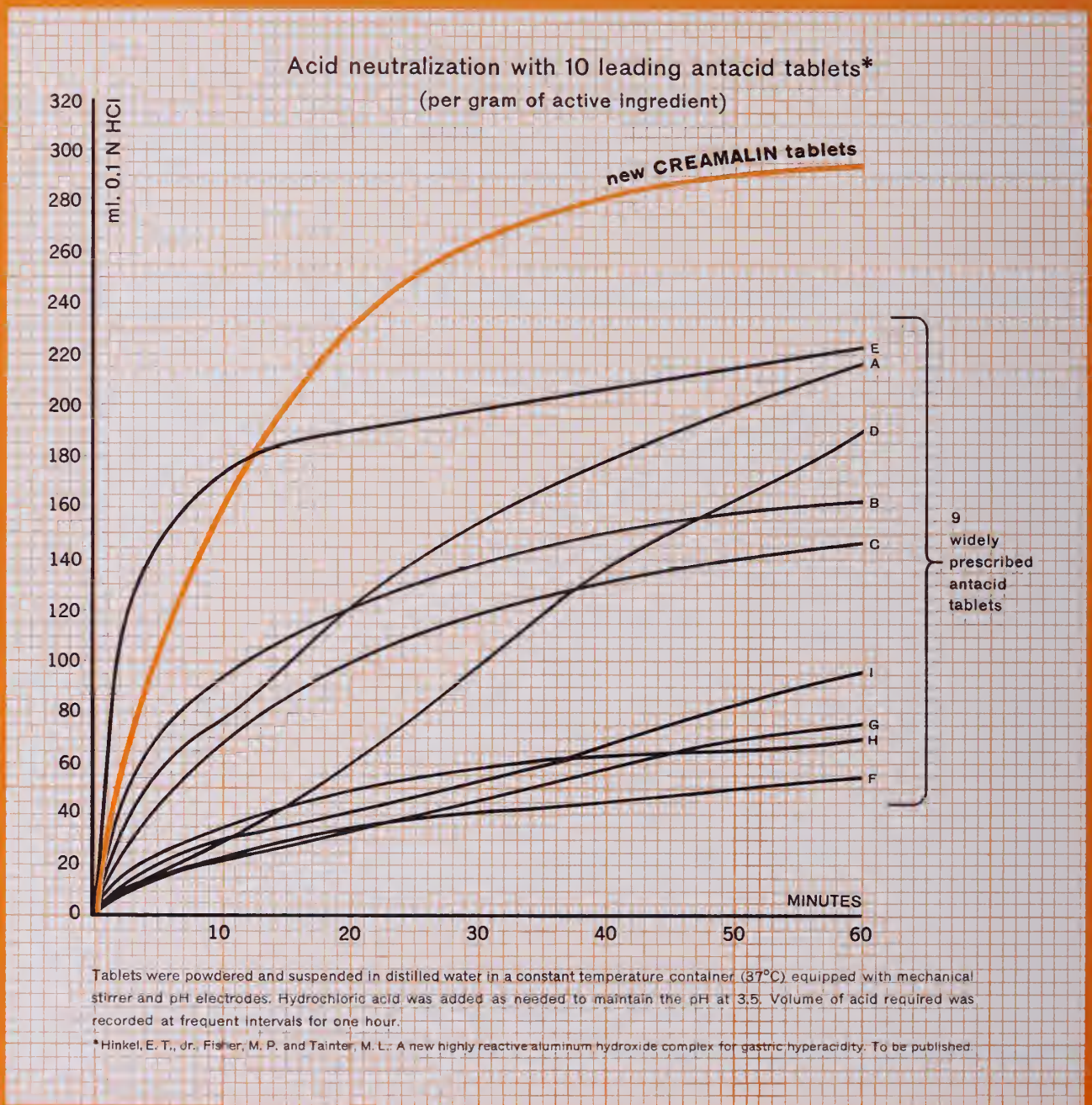
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*Hinkel, E. T., Jr. Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

In Memoriam

W. H. PENNINGTON, M.D.
Lexington
1904-1959

William H. Pennington, M.D., a general surgeon on the staff of the Lexington Clinic for 28 years, died of a heart attack while on a West Indies cruise on February 19. A graduate of the Louisville School of Medicine in 1928, he interned at St. Joseph Hospital in Lexington and served as a fellow in surgery at the Cleveland Clinic from 1929 to 1931, when he joined the Lexington Clinic staff.

He had served as president and vice president of the Kentucky Surgical Association and is a past president of the Fayette County Medical Society. He was a lieutenant colonel in the medical corps of the Army during World War II serving as executive officer of the 38th Evacuation Hospital in the Mediterranean, North Africa, and Italy.

GEORGE N. RAWLEIGH, M.D.
Paducah
1891-1959

George N. Rawleigh, M.D., who had practiced in St. Louis and Paducah, died in Paducah on February 13. He was a 1924 graduate of the St. Louis School of Medicine.

Before attending medical school, Doctor Rawleigh, a graduate of St. Louis School of Pharmacy in 1912, operated drugstores in Paducah and St. Louis. At one time he was public health physician in Paducah. Until about five years ago he had owned and operated a drug store in Paducah.

J. F. McCORMAC
Verona
1871-1959

J. F. McCormac, M.D., who practiced for 64 years in Verona, died on February 10 at St. Elizabeth Hospital, Covington, where he had been a patient since January 29.

A graduate of Ohio Medical College in 1895, Doctor McCormac had practiced in Verona since 1895. Since 1942, when he suffered a stroke, he had confined his practice to his office.

HUGH BOGGS FRALEY, M.D.
Ashland
1865-1959

Hugh Boggs Fraley, M.D., died at his home in Ashland on February 20 at the age of 93 following an extended illness. He had practiced in Ashland since 1925.

A graduate of the University of Louisville Medical School in 1895, he was born in Newcomb, Elliott County, Kentucky. He had practiced medicine since his graduation from medical school until his illness.

LEON L. SOLOMON, M.D.
Louisville
1871-1959

Leon L. Solomon, M.D., who had practiced medicine in Louisville for 63 years before retiring two years ago, died at Jewish Hospital in Louisville on February 27. Doctor Solomon was honored by Jewish Hospital in Louisville in 1941 for having served on its staff since its founding in 1902.

A native of Louisville, he had practiced there since graduation from the University of Louisville Medical School in 1894. In 1947, he was one of the first three white members to be elected to the executive committee of the Louisville Chapter, National Association for the Advancement of Colored People. He often testified on medical matters at trials in Louisville.

W. C. ROBINSON, M.D.
Lexington
1918-1959

W. C. Robinson, M.D., Lexington physician and surgeon, died at his home on March 7.

The son of Doctor and Mrs. B. F. Robinson of Fort Lauderdale, Fla., he was a native of Berea. He was a graduate of the Tulane University Medical School in 1942 and had been affiliated with the Mayo Clinic, Rrochester, Minn., for four years, and still held a fellowship there. During World War II, he was a major in the U. S. Army Medical Corps.

G. BEDFORD BROWN, M.D.
Lexington
1893-1959

G. Bedford Brown, M.D., former Lexington physician died in St. Louis, Mo., on February 18 at the age of 65. He was a native of Georgetown and a graduate of Georgetown College, Yale University, and Johns Hopkins Medical School in 1917.

An honorary life member of the Lexington Optimist Club, he was also an honorary staff member of Good Samaritan Hospital, St. Joseph's Hospital, John Graves Ford Hospital, and an emeritus member of the Fayette and Scott County Medical Societies.

THOMAS M. DORSEY, M.D.
Louisville
1886-1959

Thomas M. Dorsey, M.D., died at St. Joseph Infirmary in Louisville on February 13 at the age of 72. He operated a private clinic in Louisville.

A graduate of the University of Louisville Medical School in 1912, Doctor Dorsey was formerly on the faculty of the school in the departments of pathology and urology. He served with the Army Medical Corps during World War I, with the rank of major.

Application

FOR SPACE IN THE SCIENTIFIC EXHIBIT

1959 Annual Meeting — Kentucky State Medical Association

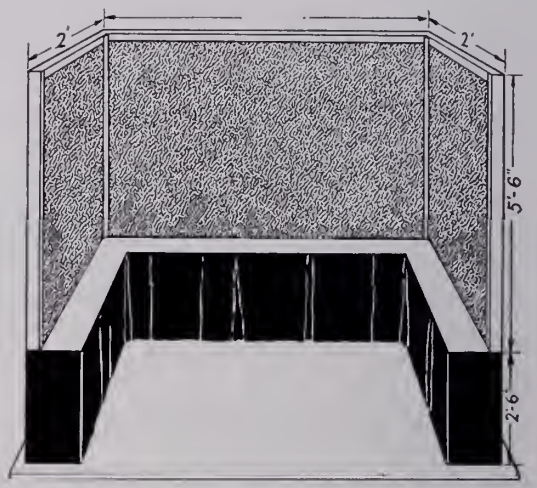
Columbia Auditorium — **Louisville, Kentucky** — **September 22, 23, 24**

Fill Out and Mail to:

EVERETT L. PIRKEY, M.D., Chairman
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

Applications for space should be received before July 1, 1959

Dimensions and structure of K.S.M.A. Scientific booth are shown in accompanying illustration



1. Title of Exhibit: .....

2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.

PLAN NOW TO ATTEND THE

108th ANNUAL MEETING *OF THE* AMERICAN MEDICAL ASSOCIATION

June 8-12, 1959, Atlantic City, New Jersey



. . . over 300 scientific exhibits . . . 57 seminars and sectional meetings . . . 60 medical motion pictures . . . daily closed-circuit telecasts.

Childbirth featured in largest combined session ever offered by A.M.A. Seven sections—Obstetrics and Gynecology; Anesthesiology; Pediatrics; Preventive Medicine; General Practice; Diseases of the Chest and Nervous and Mental Diseases present a morning long symposium.

Liver diseases presented in a combined symposium and panel session with six sections participating: Internal Medicine, General Practice, Experimental Medicine and Therapeutics, Pathology, Radiology and Gastroenterology.

Typical of the hundreds of speakers and topics scheduled for presentation:

SYMPOSIUM ON HEPATIC DISEASES

"Newer Concepts of Bilirubin Metabolism"
David Schachter, New York City, New York

"Hepatic Coma: Its Physiologic and Chemical Basis"
S. P. Bessman, Baltimore, Maryland

"Current Problems in Hepatic Pathology"
I. N. Dubin, Philadelphia, Pennsylvania

"Current Knowledge of Viral Hepatitis"
Joseph Stokes, Jr., Philadelphia, Pennsylvania

"Radiography in the Diagnosis of Hepatic Disease"
John R. Hodgson, Rochester, Minnesota

"Newer Concepts of Cirrhosis"
Gerald Klatskin, New Haven, Connecticut

PANEL DISCUSSION ON HEPATIC DISEASES

Moderator—Cecil Watson, Minneapolis, Minnesota

Atlantic City is an ideal family playground. The fabulous Boardwalk and world renowned Steel Pier are focal points of interest at this famous ocean side resort.



For advance hotel and meeting registration information write: Convention Services, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois

Meet on Nutrition May 8

The American Medical Association will sponsor a Symposium on Nutritional Problems in Medicine, featuring heart disease and disorders of nutrient absorption, on May 8 in Nashville, Tennessee.

The symposium will be held in the Vanderbilt University amphitheater and is being planned by the AMA's Council on Foods and Nutrition and the Vanderbilt University Medical School. The meeting is open to physicians, nurses, dietitians, medical students, and other interested persons.

PERTINENT PARAGRAPHS

The University of Southern California School of Medicine is offering its second annual Postgraduate Refresher Course in Honolulu and aboard the S. S. Lurline from July 29 through August 15. In addition to lectures there will be workshops in ECG and X-ray diagnosis, as well as water and electrolyte balance and the diagnosis of jaundice. The group will depart from Los Angeles on July 29 and will return to Los Angeles on August 15. Physicians may elect to return by air, arriving in Los Angeles August 11. For more information and a registration blank write to Director, Postgraduate Division, U. S. C. School of Medicine, 2025 Zonal Avenue, Los Angeles, Calif.

The fifth annual Surgery, Radiology, Pathology Symposium on Thyroid Diseases will be held May 8 and 9 at the University of Oklahoma Medical Center, Oklahoma City. The fifth in a series of annual symposiums, it is sponsored by the office of Postgraduate Education of University of Oklahoma Medical Center, the Oklahoma Association of Pathologists, Oklahoma State Radiological Society, and the Oklahoma Chapter of the American College of Surgeons. For program write: Office of Postgraduate Education, University of Oklahoma Medical Center, 801 Northeast 13th St., Oklahoma City 4, Oklahoma.

Retirement point credits may be earned by reserve Medical Corps officers who attend the scientific sessions of the thirtieth annual meeting of the Aero Medical Association in Los Angeles, California, on April 27-29, the Department of Defense announced today. This authorization covers physicians who are medical corps officers in the U.S. Army, Navy, and Air Force on inactive status. The wide interest in man's impending venture into space is expected to bring more than 1,500 members of the Association and their guests to Los Angeles.

District V of the American College of Obstetricians and Gynecologists is offering two $100 awards for the best original investigative or clinical work in the field of obstetrics and/or gynecology. Papers may be submitted by any resident in an accredited hospital in District V, which includes Kentucky. Papers must be received before August 1, 1959, and must be submitted in triplicate, without author identification on any copy. A covering identifying letter should be addressed to Edwin S. Hoffman, M.D., 766 Fisher Building, Detroit 2, Michigan.



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PUBLIC HEALTH PAGE

(Continued from page 396)

Teachers are in a strategic position to help appraise the health status of the child. Changes in appearance, behavior, scholastic work and play can easily be noted by the observant teacher. Their day to day observations of the changes may be of more importance in detecting health problems than an isolated examination by a physician. The Astoria* study showed that teachers had picked up 85% of the defects as confirmed by subsequent physical examinations. The teacher needs to be skilled in the art of health observation; and the medical profession should assist the teacher in obtaining this skill.

**Nyswander, Dorothy B.: Solving School Health Problems. The Astoria demonstration study. New York: The Commonwealth Fund, 1942.*

NEWS ITEMS

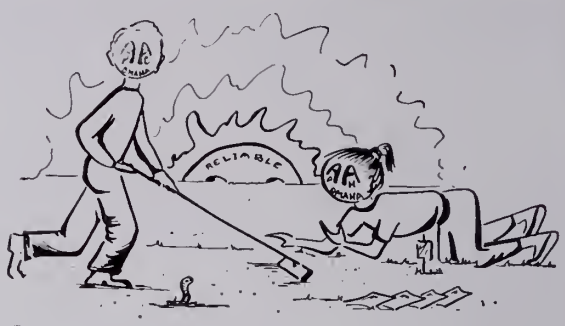
The new half-million dollar bridge over Deer Creek in Sebree will be named after **J. E. Jenkins, M.D.**, of Sebree, who had worked tirelessly to make the project a reality. A plaque on the bridge will dedicate it in his honor and a dedication ceremony is being planned after the job is completed.

A non-stock organization to produce plays depicting the life of Ephraim McDowell, noted pioneer surgeon, and other historical and cultural events concerning Danville and Central Kentucky was recently granted a charter by Kentucky's Secretary of State. Called the Ephraim McDowell Drama Association, Inc., its incorporators were **Francis M. Massie, M.D.**, William Curry, and Earl Slone, all of Lexington.

Raymond E. Jones, M.D., has opened an office in the Medical Arts Building in Louisville, where he will limit his practice to the ears, nose, and throat. A graduate of the University of Louisville School of Medicine in 1945, he interned at St. Joseph Infirmary, Louisville, took his residency training at the U. of L., Veterans Hospital, at Western Reserve and VA Hospital in Cleveland. He was a major in the Medical Corps from 1954-56.

W. E. Kazee, M.D., Olive Hill, was injured in an automobile accident near Grayson on March 5. Full details of the accident were not available at press time.

John T. O'Neil, M.D., Arlington, was injured on March 8 when his automobile collided with one occupied by a Minnesota couple four miles north of Paducah.



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0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
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Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
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Vitamin E (as tocopheryl acetates)	10 I.U.
l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

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GUILD OPTICIANS



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field*.† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

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For easy, safe, painless removal of ear wax—without instrumentation



Proved clinically effective in 4,464 (95.0 per cent) of 4,695 patients (ages 3 months to 83 years) with excess or impacted cerumen†

For patient convenience and economy, prescribe 'Cerumenex' Drops in the regular 15 cc. bottle, packaged with cellophane wrapped blunt-end dropper.

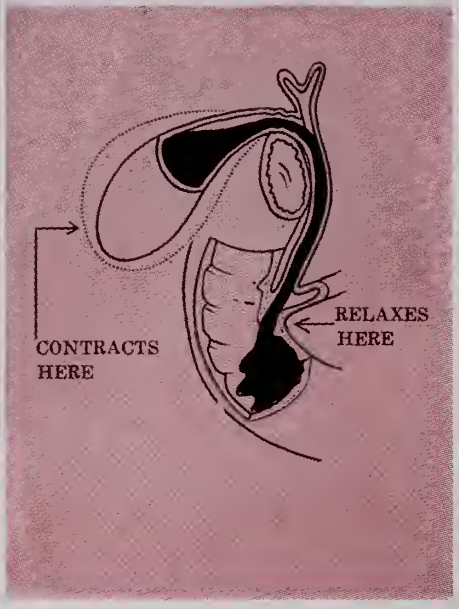
†Complete bibliography available on request

T.M.
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Senokot®
natural bowel corrective
TABLETS / GRANULES

IN CONSTIPATION



Assures bowel correction and rehabilitation because it "...acts in a way almost indistinguishable from the normal physiologic mechanism..."[1]

without mucosal irritation due to chemical contact

without incompatibilities to antacids and other medications

Supply: Tablets, small and easy to swallow, in bottles of 100. Granules, cocoa-flavored, in 8 and 4 ounce canisters.

1. Herland, A. L., Lowenstein, A.: Quart. Rev. Surg. Obst. & Gynec. 14:196 (Dec.) 1957

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OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

'NEOSPORIN'®
brand ANTIBIOTIC OINTMENT

OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { **LOTION:** Plastic squeeze bottles of 20 cc.
NEW { **POWDER:** Shaker-top bottles of 10 Gm.



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Offers combined antibiotic action for treating conditions due to susceptible organisms amenable to local medication.

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NEWS ITEMS

Katharine Dodd, M.D., distinguished professor of pediatrics at the University of Louisville School of Medicine, received the Elizabeth Blackwell Award recently for distinguished contributions to medicine. The award, presented at New York Infirmary, New York City is made annually to women physicians for outstanding contributions to the science, practice, or teaching of medicine.

Arthur R. Kasey, Jr., M.D., Louisville, has been appointed by Governor A. B. Chandler to a four-year term on the Advisory Council on Mental Health.

Donald L. Boucher, M.D., has joined the Hazard Clinic where he will practice otolaryngology. A graduate of the University of Minnesota in 1953, Doctor Boucher interned at St. Joseph's in St. Paul, Minnesota and took his residency training at the University of Minnesota.

Milton M. Green, M.D., has been named acting superintendent of Western State Hospital in Hopkinsville, replacing **Robert G. Blackwelder, M.D.,** who died on February 1 of a heart attack. Doctor Green was formerly a staff physician at the hospital.

County Society Reports

McCracken

The January meeting of the McCracken County Medical Society was held in Boswell's Restaurant in Paducah on January 28. Walker Turner, M.D., president, presided.

Featured speaker was Carroll L. Witten, M.D., Louisville, who talked on "Forand and Freedom." His presentation was followed by a discussion period.

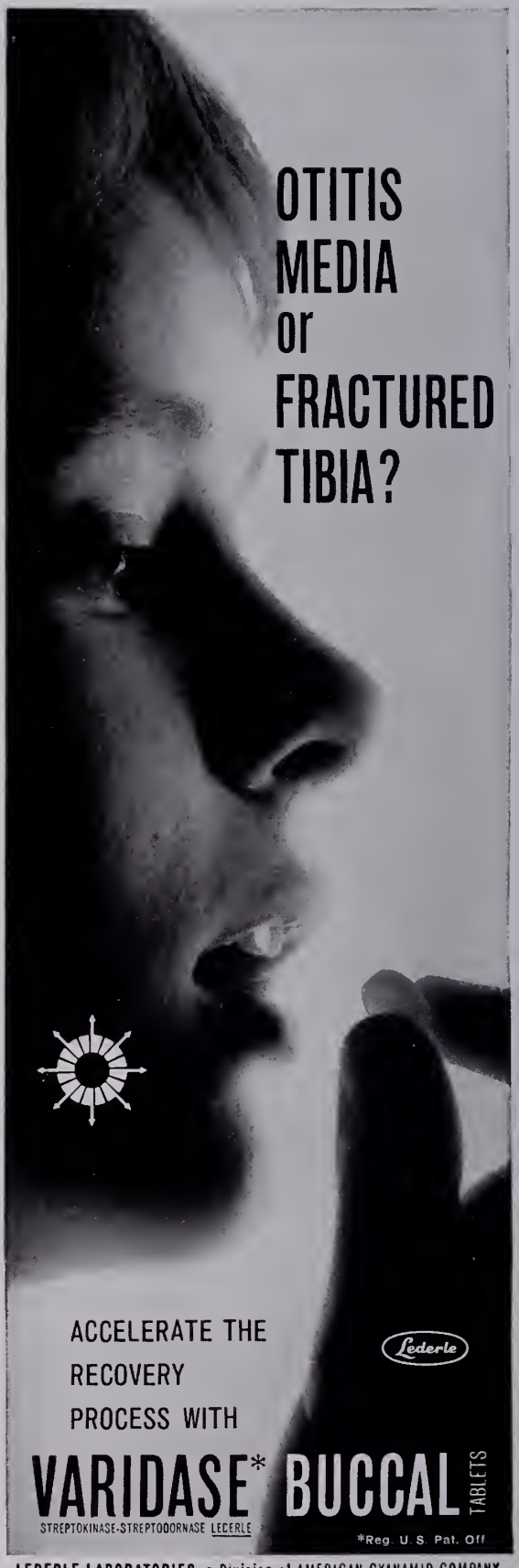
Louis Myre, M.D., announced that his committee would welcome any suggestions on subjects or individuals that members of the Society would like discussed during the year.

Norman Parrott, M.D., health officer of the Paducah-McCracken County Health Department announced that a series of classes on care of the aged are being conducted by the department for operators of nursing homes and that a letter was being sent to all physicians stressing the need for thorough reporting of communicable diseases—including encephalitis, hepatitis, venereal disease, and tuberculosis.

Burton Haley, M.D., reported that the Civic Center of the Junior Chamber of Commerce was nearing completion and urged each physician to participate in the fund program on an individual basis.

Doctor Turner announced that "MD International" would be shown over NBC TV on February 22.

A letter from the Council on Food and Nutrition of the AMA regarding the role the medical profession plays in alerting the public to the dangers of overweight was read.



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[redacted]

in premenstrual tension

only neo Bromth®

treats the whole syndrome





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The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee

83% MAJOR (Grade I and II) IMPROVEMENT*

in Rheumatoid Arthritis

*Using combined drug therapy with **PLAQUENIL®** or Aralen® as maintenance therapy. With Plaquenil or Aralen alone 62% grade I and II improvement. (Scherbel, A.L.; Harrison, J.W., and Atdjian, Martin: Cleveland Clin. Quart. 25:95, April, 1958. Report on 805 patients with rheumatoid arthritis or related diseases.)

Reasons for Failure:

1. Treatment discontinued too soon (percentage of patients improved increases substantially after first six months).
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Plaquenil sulfate is supplied in tablets of 200 mg., bottles of 100.

Dose: Initial — 400 to 600 mg. (2 or 3 tablets) daily.
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as they like it...

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as they need it...

ACHROMYCIN® V

Tetracycline with Citric Acid Lederle

- broad spectrum control of more than 90 per cent of antibiotic-susceptible infections seen in general practice[1]
- fast, high concentrations in body fluids and tissues
- no irreversible side effects reported, excellently tolerated
- readily miscible in water, juices, formula.

ACHROMYCIN V: 10 cc. plastic dropper bottle for precise dosage; 100 mg. per cc. (20 drops). *Dosage:* one drop per pound body weight per day.

ACHROMYCIN V Syrup: Each teaspoonful (5cc.) contains equiv. 125 mg. tetracycline HCl. Bottles of 2 and 16 fl. oz. *Dosage:* at 45 lbs., one teaspoonful 4 times daily; adjust for other weights.

1. *Based on six-month National Physicians Survey.*

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Active medical staff of six physicians. Physicians available at all hours. 24 hour efficient and cheerful nursing care WITH SPECIAL EMPHASIS ON MAKING EACH PATIENT FEEL LOVED, WANTED AND IMPORTANT.

Special diets prepared and tray service to all rooms at no extra charge.

Diversional activities, physio-therapy treatments, rehabilitation program and emergency facilities available.

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PRIVATE, SEMI-PRIVATE AND WARD ACCOMMODATIONS AVAILABLE. Private and semi-private rooms with intercommunication, beautifully decorated and furnished, beds equipped with Trendelenburg springs and innerspring mattresses.

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NEWS ITEMS

Ben F. Allen, M.D., a past president of the Fleming County Sportsman's Club, was awarded a special plaque on the "Jim Thomas Outdoor Guide Show" over station WLW-T as the outstanding member of the local club. Doctor Allen, one of the founders of the club, is an avid fisherman and hunter.

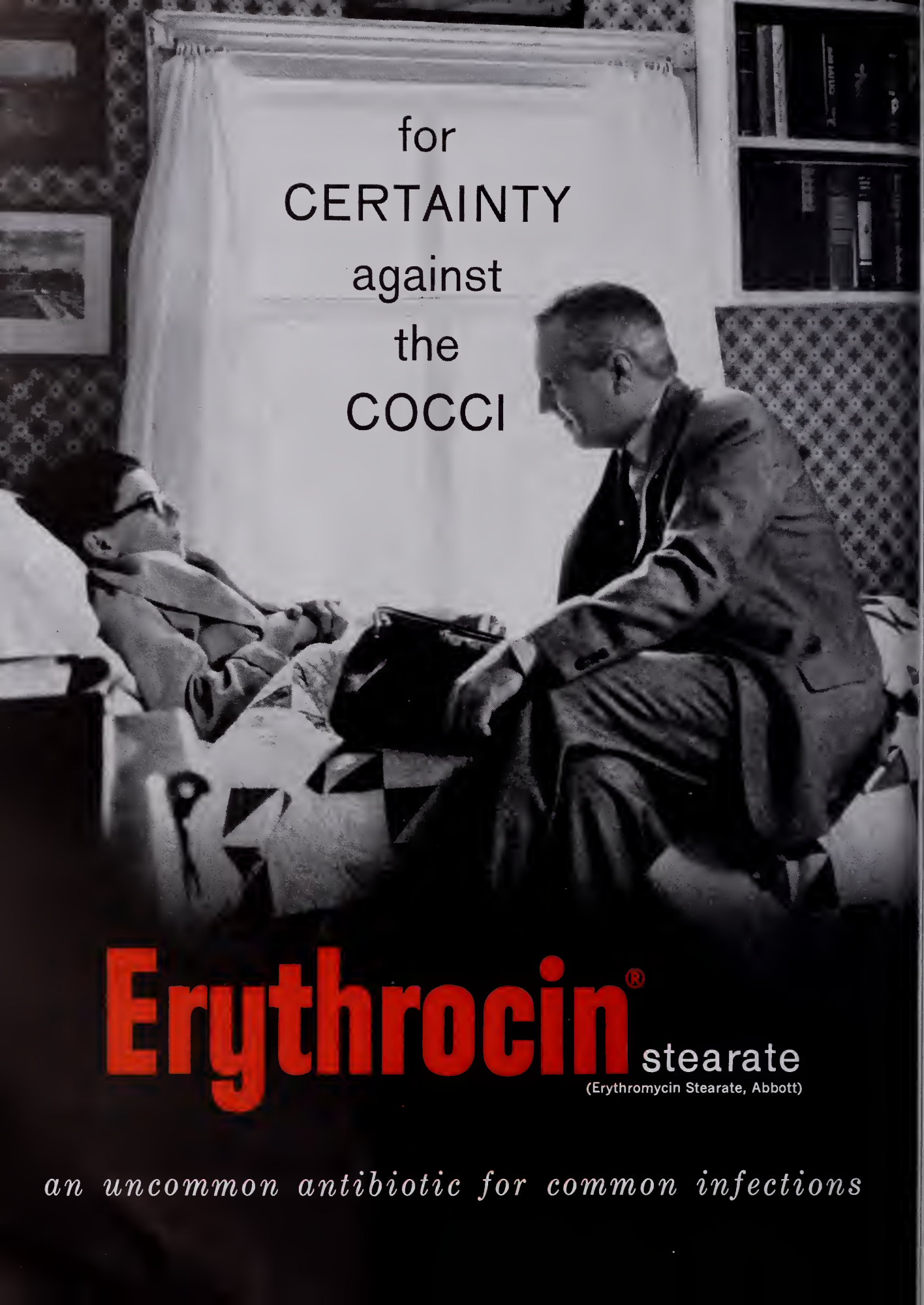
W. E. Davis, M.D., who has been in general practice for the past 20 years in North Middletown, is giving up his active practice to become health officer for Bourbon, Harrison, and Scott counties. He plans to take over his duties after a trip to England.

Alec Spencer, M.D., West Liberty, was honored by the West Liberty Kiwanis Club as the "outstanding Boy Scout Leader in the Bluegrass Council" and was presented a Scroll of Honor by West Liberty's Boy Scout Troop No. 140. In making the award the Kiwanians said that Doctor Spencer has sparked the annual fund drives for scouting every year, has donated equipment and often purchased needed items for the troop, served as scoutmaster himself; has taken the scouts on trips, and even built a scout meeting place near his home and later provided a brownie camp nearby.

Paul E. Goode, M.D., has given up his practice in Hartford and Ohio counties and has moved to Jackson, Mississippi, where he will be associated with Mayo Clinic.

Dorothy Magallon, M.D., former director of communicable-disease control for the City-County Health Department, is now at the State Department of Health working as an epidemiologist. She will be working with **Patricia Conlan, M.D.,** acting director of the Bureau of Medical Services, in the field of communicable diseases, tuberculosis, and venereal disease. Both Doctors Magalon and Conlan plan to study for master-of-public-health degrees on leave from the State Health Department, starting next fall.

An Oregon Cancer Conference in Portland, under the joint sponsorship of the Oregon State Medical Society, the Oregon Division of the American Cancer Society, the University of Oregon Medical School, and the Oregon Academy of General Practice, will be held in Portland on July 16 and 17. The Conference is planned for midsummer as a special feature of the Oregon Centennial celebration. Guest speakers from the University of Miami School of Medicine, Duke University School of Medicine, and the University of Oregon will be included in the program. A copy of the complete program and hotel reservation forms may be obtained by writing to Roscoe K. Miller, Executive Secretary, Oregon State Medical Society, 1115 S. W. Taylor St., Portland 5, Oregon.



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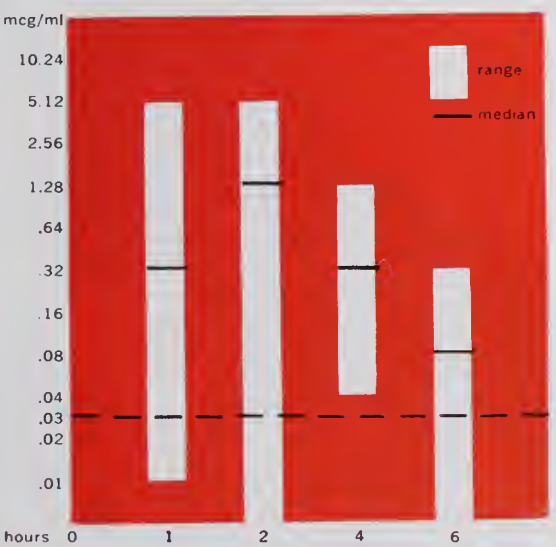
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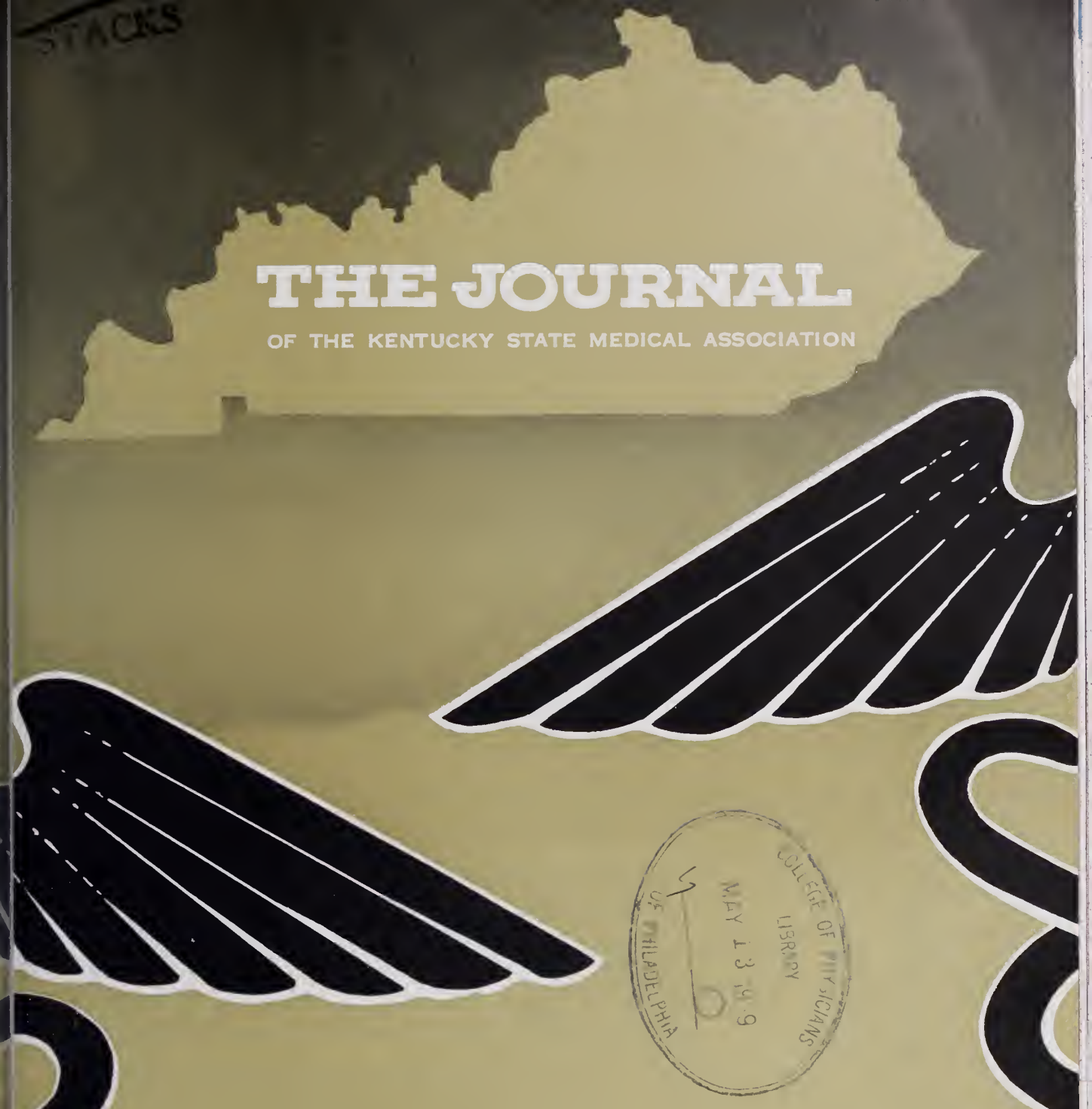
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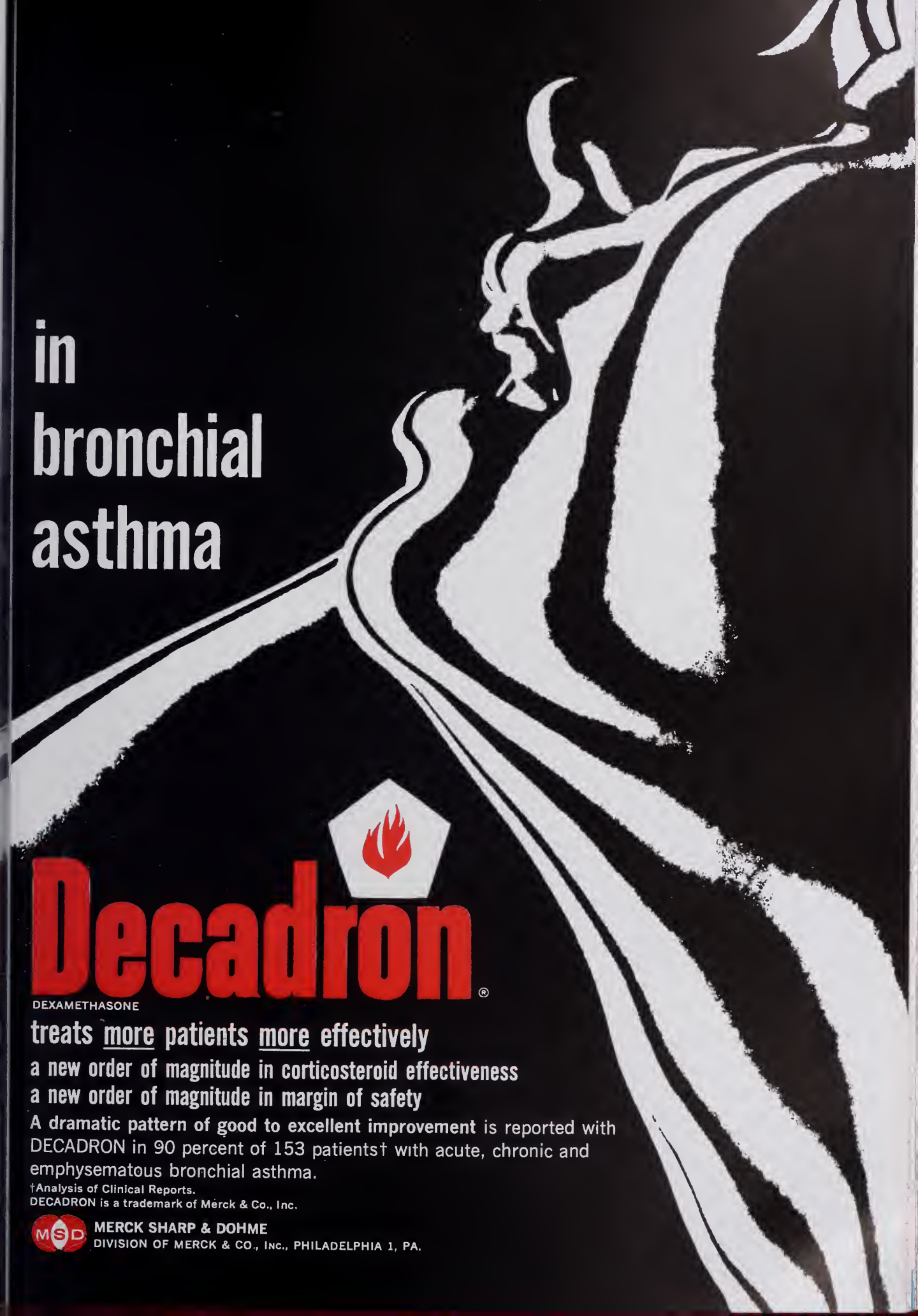
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message from the President

WE have spoken! The speakers were the members of the KSMA House of Delegates at Lexington whereby the principle of freedom of choice of physician was affirmed and unequivocable opposition to physician's participating in closed panel systems which exert economic or administrative pressure in influencing the patients' right to participate was expressed.

Did we speak wisely at Lexington? I think so, for our answer was based on freedoms—our nation was founded on want of freedoms. More than three-fourths of the population of the United States want to choose their own doctor according to survey. Therefore, we have upheld our principles and have also given the people what they want—freedom.

While the medical profession has long been striving to maintain full acceptance of the principle of the individual's right to choose his own physician, certain third parties in recent years have moved in the opposite direction. In some cases members of the medical service plans are required to use physicians employed by this plan. Otherwise they must pay for medical services obtained elsewhere.

These health and hospitalization plans that are denying free choice of physician have created a wall between the patient and his doctor. How then can we tear down this wall?

First, I believe the physicians throughout Kentucky should shoulder an interest in this problem on a state level. Regardless of whether or not this problem is pressing on you now—it will mushroom.

Futhermore, we can render competent medical care at a cost which patients can afford, by assuring the public of the competence of licensed physicians and by policing our ranks to eliminate professional incompetence or economic abuse.

With a concerted effort and unity we can make Medicine's voice be heard over the din of the wall builders.

Robert W. Roberson

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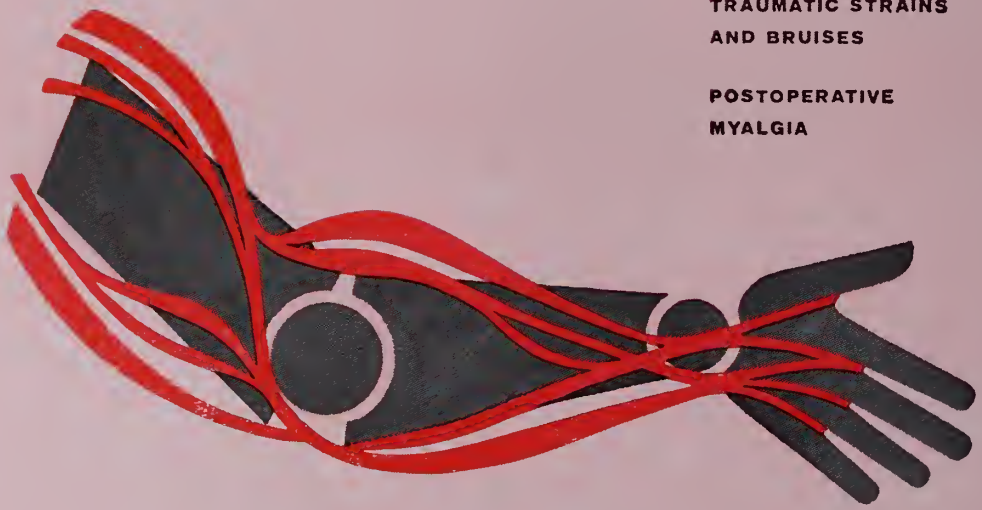
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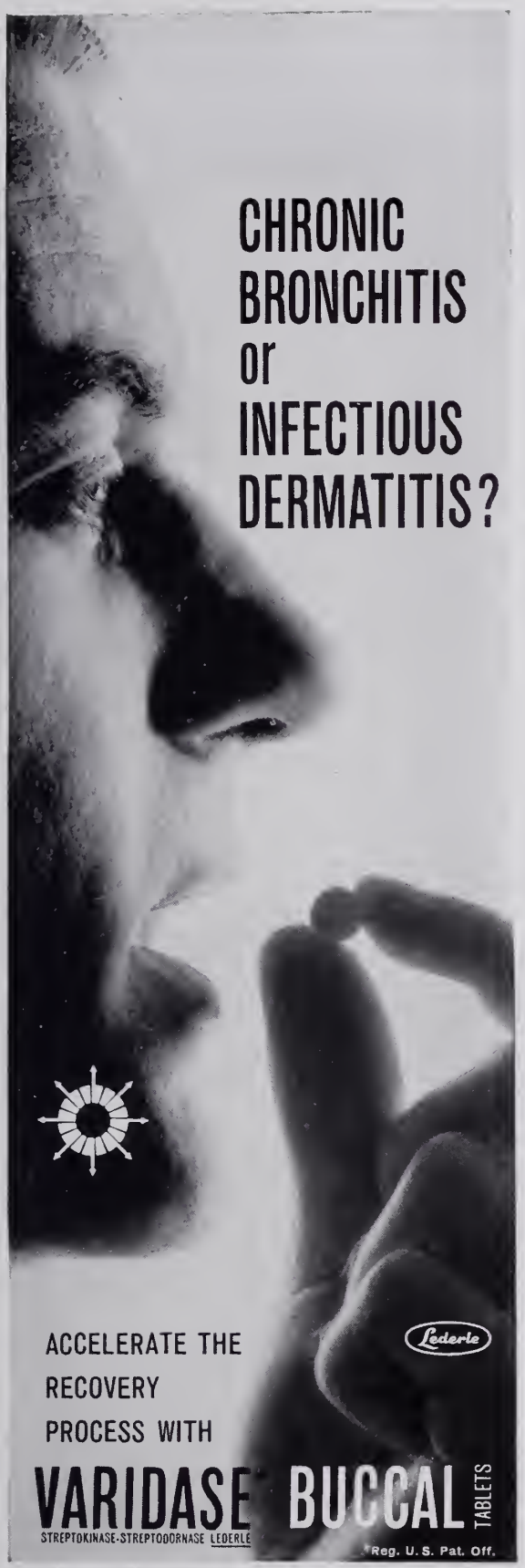
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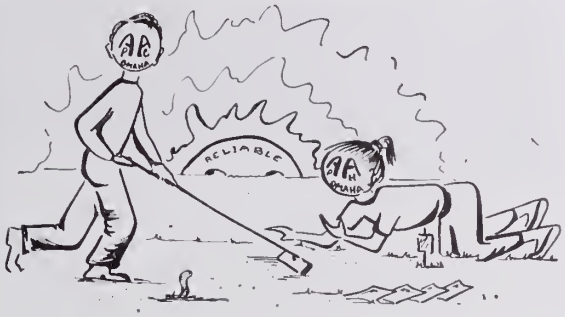
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IN THE BOOKS

PHYSICAL DIAGNOSIS: by John A. Prior, M.D. and Jack S. Silberstein, M.D.; published by C. V. Mosby Company, St. Louis, 1959; 388 pages; price $7.50.

The authors apparently had the medical student foremost in mind when writing this book. They have not attempted to compile a reference book of all known physical findings and signs. The stated objective is "to acquaint the student with the basic tools of his trade, namely, the history, physical examination, and essential medical terminology."

The section on history taking is much more complete than that in most books on physical diagnosis. In addition to presenting an orderly form for developing the history, many suggestions are given to make this part of the examination easier on the patient and the physician.

The section on physical examination is broken down into the conventional anatomical areas or organ systems. Little time is wasted in lengthy explanations of the causes of some of the sounds and sensations observed. The use of eponyms is strenuously avoided. The term Corrigan pulse, Austin Flint murmur, and a host of others, do not appear in this book. The section does adequately describe normal findings and the major pathological variations.

A separate section on the pediatric examination is included to augment the general text.

Little attempt is made to correlate the history and physical findings with syndromes or disease states. One is referred to other sources for this type of information. This is a book on history taking and physical examination, no more and no less.

Stuart Graves, Jr., M.D.

REHABILITATION MEDICINE: by Howard A. Rusk, M.D., published by C. V. Mosby Company, St. Louis, 1958; 572 pages; price, $12.

This book is one of the most significant and complete texts published in the field of Physical Medicine and Rehabilitation in recent years. Dr. Rusk is a recognized authority in rehabilitation and has selected excellent collaborators.

The importance of detailed evaluation of the physically disabled is stressed. The criteria for measurements made necessary by the multiple systems involved is aptly presented. The range of joint motion chart is one outstanding feature.

The techniques used in physical medicine are described in an excellent, concise manner. The physical agents, indications for their use and their contraindications are well-described although quite brief. The section on exercise is exceptionally well-organized and illustrated. The principles of occupational therapy in relation to psychologic, physical, and vocational techniques are presented in easily understood terms.

The chapters on activities of daily living, testing and training and rehabilitation nursing are appropriately contiguous. They are detailed enough to give the student an excellent background and guidance. These are two of the many areas where Dr. Rusk and his associates have excelled in the past.

There is incorporated a very important discussion on the uses of crutches, braces and wheelchairs which is valuable knowledge to the practicing physician.

The highly specific techniques and equipment used in self-help devices and functional splinting should be of great help to physicians and therapists active in or preparing for rehabilitation programs. Most of the latest developments in this relatively new field are presented. Management of the disabled housewife is a little-known science and many of these self-help devices and splints facilitate their training. The methods of evaluation and training disabled housewives is presented in the text.

The psychological, social and vocational problems associated with the physically disabled and their rehabilitation are presented in considerable detail. The student of rehabilitation and medicine can obtain invaluable guidance from these very clearly presented discussions. This information will help the physician and people in other disciplines in approaching the patient as a team with real understanding of the part that others must play in rehabilitation.

In Part II the information furnished in Part I is used to indicate the physical medicine and rehabilitation approach to specific conditions. The conditions most frequently met in rehabilitation programs have been selected. Fortunately these have been dealt with in enough detail to be significant.

Metabolic diseases including arthritis, diabetes mellitis, poisoning, hematological diseases and metabolic bone diseases are considered. Post traumatic conditions and the latest information on amputees is presented. There is a very excellent discussion on many muscular, neuro-muscular and neurological conditions, including cerebral palsy, poliomyelitis and paraplegia or quadriplegia.

Considerable information relative to rehabilitation is presented in cases of cancer, pulmonary problems and cardiovascular disease.

The text is concluded with brief discussions on special problems in pediatric and geriatric patients

(Continued on page 540)

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dosage: In edema—one or two 50 mg. tablets of HYDRODIURIL once or twice a day.

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supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) in bottles of 100 and 1,000.

*HYDRODIURIL and DIURIL are trademarks of Merck & Co., INC.

Additional information on HYDRODIURIL is available to the physician on request.

bibliography: 1. Esch, A. F., Wilson, I. M. and Freis, E. D.: 3,4-Dihydrochlorothiazide: Clinical Evaluation of a New Saluretic Agent. Preliminary Report; M. Ann. District of Columbia **28**:9, (Jan.) 1959. 2. Ford, R. V.: The Clinical Pharmacology of Hydrochlorothiazide; Southern Med. J. **52**:40, (Jan.) 1959. 3. Fuchs, M., Bodi, T., Irie, S. and Moyer, J. H.: Preliminary Evaluation of Hydrochlorothiazide ('HYDRODIURIL'); M. Rec. & Ann. **51**:872, (Dec.) 1958. 4. Moyer, J. H., Fuchs, M., Irie, S. and Bodi, T.: Some Observations on the Pharmacology of Hydrochlorothiazide; Am. J. Cardiol. **3**:113, (Jan.) 1959.

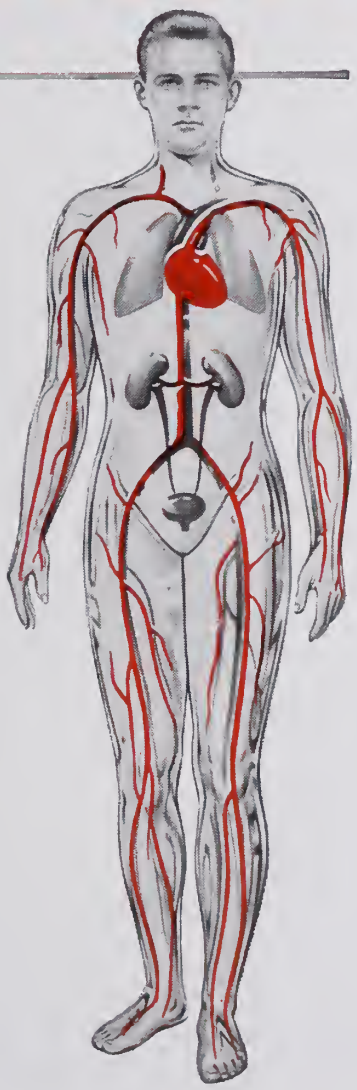
HYDRODIURIL (HYDROCHLOROTHIAZIDE)

- highly-active derivative of chlorothiazide
- qualitatively similar to DIURIL® but at least 10 to 12 times more potent by weight
- loss of potassium is clinically insignificant in the great majority of patients on normal diets

HYDRODIURIL*

NEW RELEASE

HYDROCHLOROTHIAZIDE



IN HYPERTENSION:

- effective by itself in some patients—markedly potentiates other antihypertensive agents
- provides background therapy to improve and simplify the management of all grades of hypertension
- has been reported by some investigators to have a greater antihypertensive effect in some patients than chlorothiazide at equivalent dosage
- does not lower blood pressure in normotensives
- reduces dosage requirements for other antihypertensive agents, often with concomitant reduction in their distressing side effects
- smooths out blood pressure fluctuations

precautions: It is important that the dosage be adjusted as frequently as the needs of the individual patient demand. When HYDRODIURIL is used with a ganglion blocking agent, it is mandatory to reduce the dose of the latter by at least 50 per cent, immediately upon adding HYDRODIURIL to the regimen.

HYDRODIURIL has shown no adverse effects on renal function; for this reason it may be used with excellent results even in patients for whom the organomercurials are contraindicated because of renal damage.

The excretion of potassium is much lower than that of sodium or chloride and, as is the case with DIURIL®, the loss of potassium is clinically insignificant in the great majority of patients on normal diets. If indicated, potassium loss may easily be replaced by including potassium-rich foods in the diet (orange juice, bananas, etc.).

MSD MERCK SHARP & DOHME
Division of Merck & Co., INC. Philadelphia 1, Pa.

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Uneventful Recovery

the pattern of

GLUCOSAMINE-POTENTIATED TETRACYCLINE

therapy

COSA-TETRACYN*

capsules
125 mg., 250 mg.

oral suspension
orange flavored, 2 oz. bottle, 125 mg. per teaspoonful (5 cc.)

pediatric drops
orange flavored, 10 cc. bottle (with calibrated dropper), 5 mg. per drop (100 mg. per cc.)

Note: Rapid and high initial antibiotic blood levels are an important factor in uneventful recoveries. Glucosamine potentiation provides the fastest, highest tetracycline levels available with oral therapy. Bibliography and professional information booklet available on request.

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PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, N. Y.

*Trademark for glucosamine-potentiated tetracycline

2½ minutes of your time reading about Trancopal may change your prescription habits when treating musculoskeletal and psychogenic disorders.

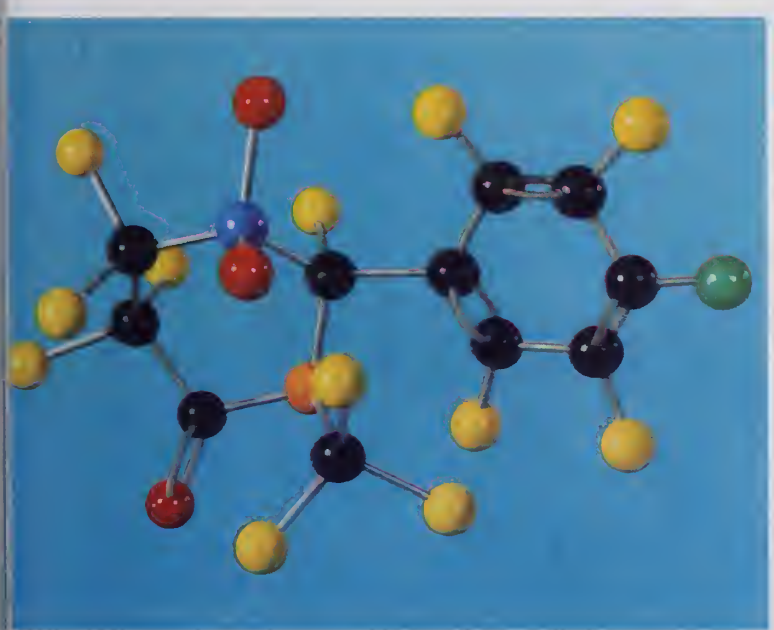
Trancopal®

*the first true tranquilaxant**

Potent MUSCLE RELAXANT

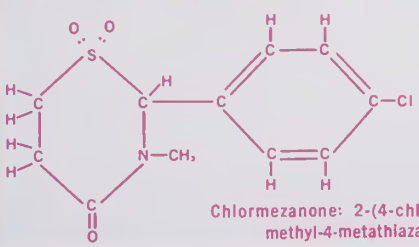
...Equally effective as a TRANQUILIZER

* **tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Thoroughly evaluated clinically...

Clinical studies of 4092 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.

In musculoskeletal conditions[1]

effective in 91% of patients

INDICATIONS

Low back pain (lumbago)
Bursitis
Osteoarthritis
Fibrositis
Myositis
Postoperative myalgias
Neck pain (torticollis)
Rheumatoid arthritis
Disk syndrome
Joint disorders (ankle sprain, tennis elbow, etc.)

By relieving muscle spasm and pain, Trancopal permits early and active purposeful exercise and physical therapy to accomplish maximal benefits for rapid recovery.

Trancopal

Dosage: One Caplet (100 mg.) orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

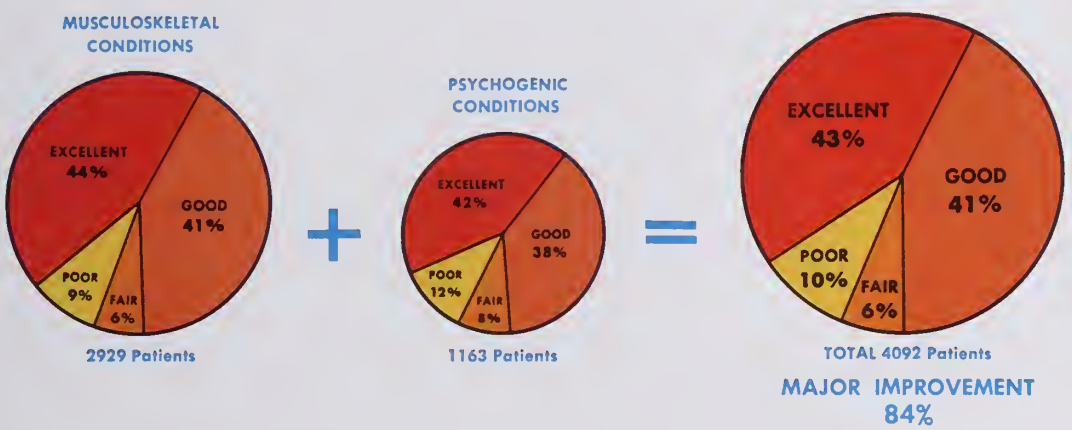
In anxiety and tension states[1]

effective in 88% of patients

INDICATIONS

Anxiety and tension states	Dysmenorrhea
Premenstrual tension	Asthma
Emphysema	Angina pectoris

Because of its exceptional calmative property, Trancopal "...allows the patient to use his energies in a more productive manner in overcoming his basic problem."[2]



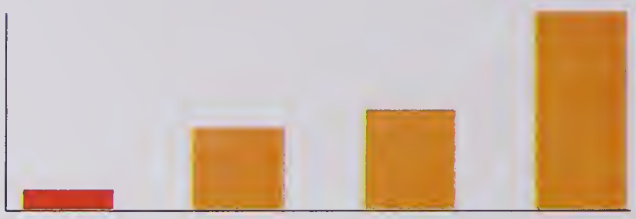
Of the total patients treated, Trancopal produced excellent results in 43 per cent, good results in 41 per cent, fair results in 6 per cent, and poor results in 10 per cent.

Better tolerated and safer than older drugs[3]

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work — or play. There are no known contraindications. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage.
Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

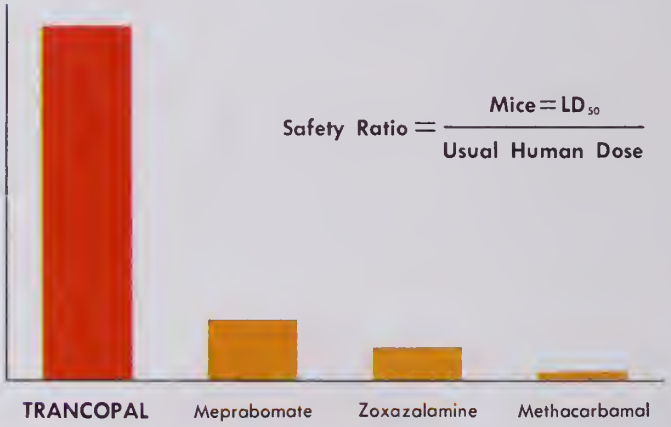
Comparison with 3 widely used central relaxants

When compared with three widely used central relaxants for activity, safety and clinical effectiveness, Trancopal offers definite desirable advantages.



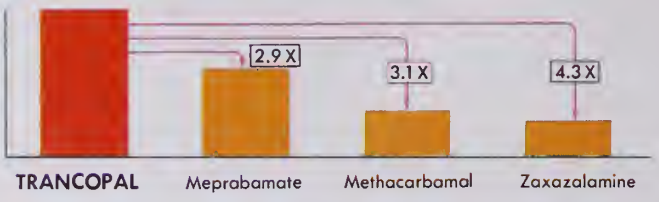
for activity

In the usual human dose, Trancopal is four to ten times as potent per milligram.



for safety

Comparative pharmacologic tests showed that Trancopal is up to thirteen times as safe or up to thirteen times less toxic. The measure of safety was the LD_{50} in mice/usual human dose.



for clinical effectiveness

A clinical comparison in low back pain, torticollis, bursitis and anxiety states showed that Trancopal is up to four times as effective. Each of the 40 patients received all four drugs in random rotation for several days. Although each of the four gave some relief, only the one providing the most effective relief was recorded.

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Cooperative Study, Department of Medical Research, Winthrop Laboratories. · 2. Gans, S.E.: To be published. · 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

Trancopal

Potent
MUSCLE RELAXANT
...Equally effective as a
TRANQUILIZER

Winthrop Laboratories / New York 18, New York

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

Printed in U. S. A. 3-59 (4027)

REACHING FOR THOSE 9B's NEARLY PUT ME ON THE SHELF...



Reaching for 9B shoes and other top shelf sizes is no joke . . . it gave me a terrible kink in my back.



Before the day was over, I could hardly stoop to push a shoehorn.



I called my doctor that night and picked up the tablets he prescribed.



The pain went away fast—in just 15 minutes—and I was back on the job the next morning! But not one 9B customer came in the whole day!

Percodan®-Demi & Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

ACTS FASTER — usually within 5-15 minutes. **LASTS LONGER** — usually 6 hours or more. **MORE THOROUGH RELIEF** — permits uninterrupted sleep through the night. **RARELY CONSTIPATES** — excellent for chronic or bedridden patients. **VERSATILE** — new "demi" strength permits dosage flexibility to meet each patient's specific needs. PERCODAN-DEMI provides the PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

AND THE PAIN WENT AWAY FAST

Endo®

Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,628,185

(Continued from page 530)

which certainly rounds out a very complete approach to rehabilitation medicine.

This book is highly recommended as a text or reference book for the physician, nurse, psychologist, social worker, vocational counselor, physical therapist, occupational therapist, speech therapist or anyone else interested in rehabilitation of the physically handicapped.

Rex. O. McMorris, M.D.

DIFFICULT DIAGNOSIS: A Guide to the Interpretation of Obscure Illness; by H. J. Roberts, M.D.; published by W. B. Saunders Company, Philadephia and London, October, 1958; 913 pages; price, $19.

As stated by its author, a practicing internist, this book presents a system for the diagnostic approach of obscure illness and is oriented on an advanced postgraduate level.

Part I comprises the greater portion of the 913 page book. It presents, in groups, related diseases which frequently produce puzzling illness. There are 17 groups presented. This includes diseases grouped by systems and others such as "The Dyscollagenoses" and "Obscure Postoperative Complications." All presentations and discussions are brief and concise. Part I also contains an excellent atlas on systemic skin disorders. Part II contains a classification and analysis of useful diagnostic procedures. There is an index of signs, symptoms, and laboratory manifestations. Both parts are supplemented with lists containing some 3000 pertinent references.

This book contains a wealth of material. As the author points out, the experience and skepticism of the individual clinician will dictate to him the place of this text in his analysis of difficult case material. The members of my staff have found it helpful in preparing for CPC's and other conferences and in reviewing for their Board examinations.

It is the opinion of the reviewer that this book will be a helpful addition to the library of any physician who will become sufficiently familiar with its organization and content to use it efficiently.

J. R. Gott, Jr., M.D.

Books Received

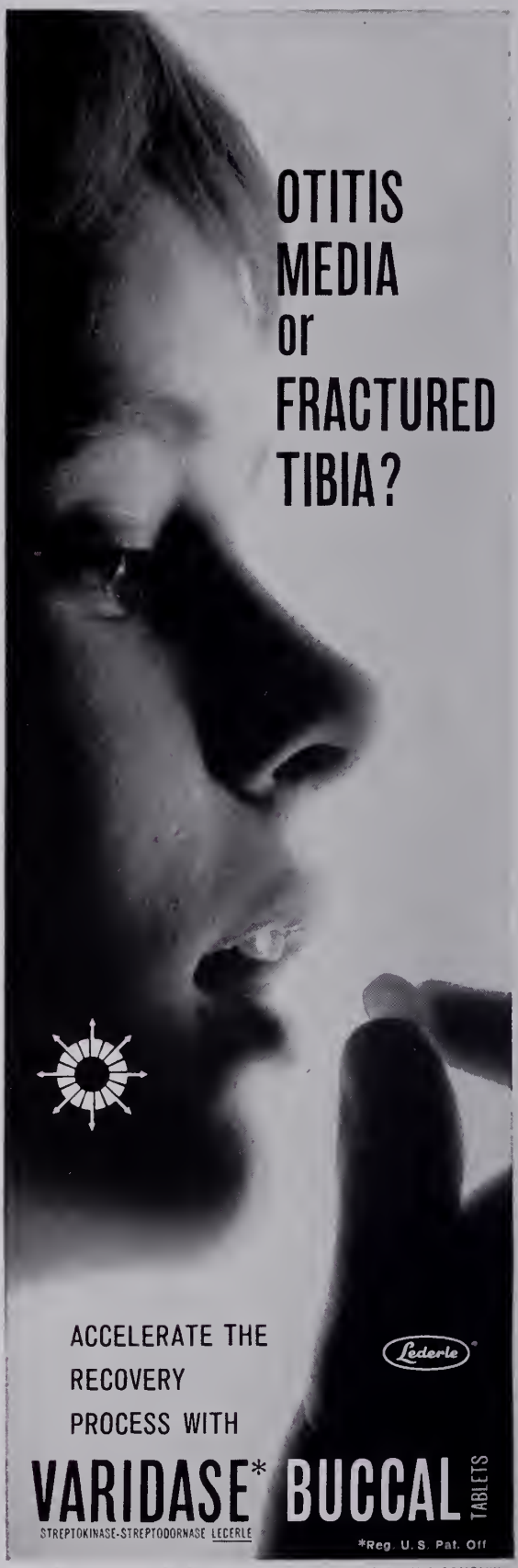
Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

A DOCTOR REMEMBERS: by Edward H. Richardson, M.D., published by the Vantage Press, New York.

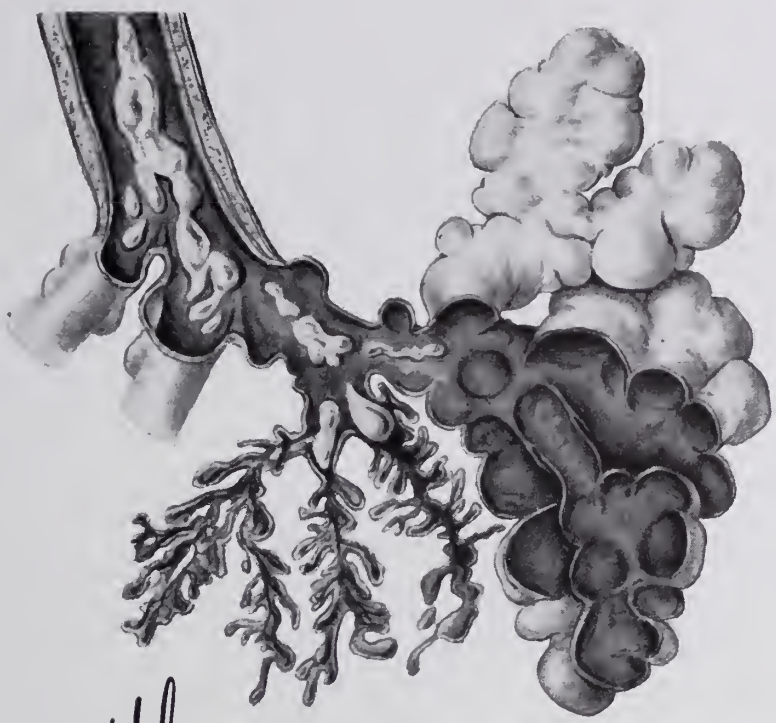
PHYSIOLOGY IN OBSTETRICS AND GYNECOLOGY: revised by Maria Ebner, published by E. S. Livingstone, Ltd., Edinburgh and London (The Williams & Wilkins Co., Baltimore, exclusive U. S. Agents).

NAVY SURGEON: by Rear Admiral Herbert L. Pugh (M. C., Ret.), published by J. P. Lippincott Company, Philadelphia.

SURGICAL PATHOLOGY: by Lauren V. Ackerman, M.D., published by C. V. Mosby Company, St. Louis.



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



Clear the air

with ALEVAIRE®

inhalation therapy

WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
PERTUSSIS
CROUP



Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

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NEW YORK 18, N Y

Alevaire, trademark reg. U.S. Pat. Off.

PUBLIC HEALTH PAGE

Public Health Nurse

RUSSELL E. TEAGUE, M.D.

Commissioner of Health, Commonwealth of Kentucky

PUBLIC health nursing was first introduced to the citizens of Kentucky by religious and philanthropic organizations. In the cities of Louisville and Lexington the service evolved from a desire of the people to meet the needs of the sick who were indigent.

In Louisville ten young ladies, one of whom was Miss Annie Veech, later to become Doctor Annie Veech, who were members of the Order of the King's Daughters, were inspired to give care to the sick poor. In 1892 these girls started the District Nurse Association and a graduate nurse was employed to visit the sick poor, nurse them, and supply them with bedding or other sick room necessities as the need arose.

Among the first reports of public health nurses being maintained through public funds was in Louisville in 1907. Seven nurses were employed to visit the homes of tuberculosis patients and to work in the tuberculosis clinic and to give services, when required, at the Louisville School for Anemic Children, which was at that time a part of the Louisville School System.

The Kentucky Board of Tuberculosis Commissioners, created by an act of the Legislature in 1912, employed nurses to visit counties with the intent of developing local public health nursing services.

A Public Health Nurse Act was passed by the Legislature in 1918. It was to permit the employment of registered nurses by public or private organizations not operated for profit, and the nurses responsibilities were for "the cure and prevention of tuberculosis and other diseases and to render aid in times of war or emergency to the sick, afflicted, injured or distressed from any cause, under the supervision and direction of the state board of health."

At present there are approximately 308 public health nurses employed in both official and non official agencies, such as the State and County Health Departments, Crippled Children's Commission, Visiting Nurse Services, Boards of Education, Frontier Nursing Service, American Red Cross, United Mine Workers, and Armed Health Services. Approximately 257 of the above number of public health nurses are employed in local health departments.

In carrying out the following activities, the public health nurse works under the medical direction of the family physician and health officer.

Participates in epidemiologic investigations in such problems as tuberculosis, venereal disease, infectious hepatitis, food poisoning and various chronic illnesses.

Teaches and supervises members of the family and others in giving nursing care.

Gives pre and post hospital care to tuberculosis patients.

In selected areas, gives nursing care and rehabilitation to the chronically ill and aging.

Provides health counseling to families of the mentally ill and assists in the rehabilitation of these patients.

Obtains laboratory specimens for diagnostic tests and gives immunizations as directed.

Observes home environment in relation to the elimination of hazards.

Works as a part of the health team in the community in planning for a more healthful community environment.

Observes and reports to physician the needs of the patient and family.

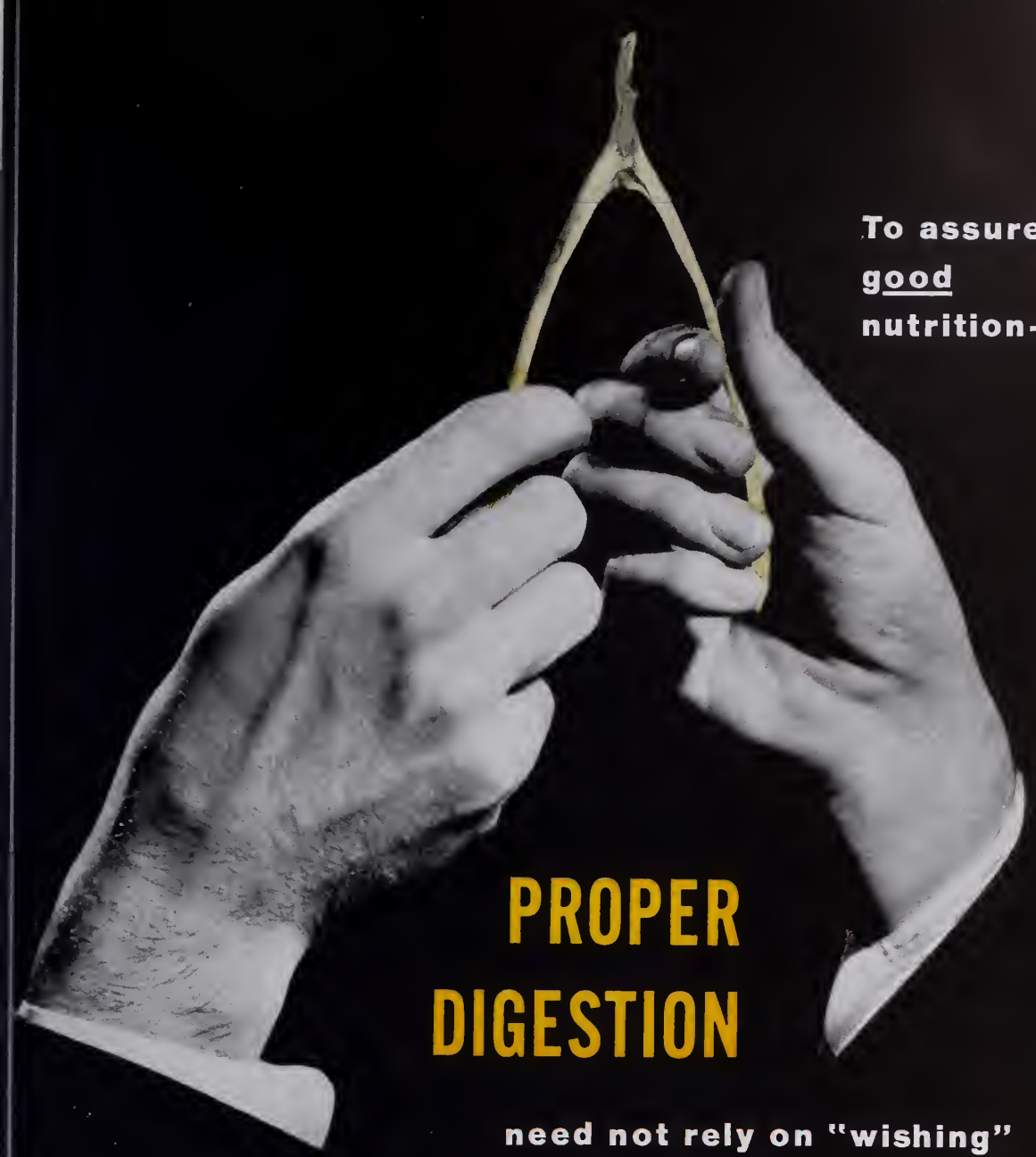
Participates in the planning for and the carrying out of health services for the school age child in the school, home and community.

Provides health information and makes known health resources to classroom teachers.

Participates in the dissemination of health information in group conferences and classes, as well as material for newspapers, radio and television.

Assists with orientation, instruction and guidance of new staff members, and of nursing and medical students.

Our future goals are to develop an adequate supply of public health nurses within our State and to have them prepared to meet ever changing needs in our society.



To assure good nutrition—

PROPER DIGESTION

need not rely on "wishing"

Each double-layered Entozyme tablet contains:

Pepsin, N.F. ..... 250 mg.
—released in the stomach from gastric-soluble outer coating of tablet.

Pancreatin, U.S.P. ..... 300 mg.

Bile Salts ..... 150 mg.
—released in the small intestine from enteric-coated inner core.

A. H. ROBINS CO., INC.
Richmond 20, Virginia
Ethical Pharmaceuticals of Merit since 1878

As a comprehensive supplement to deficient natural secretion of digestive enzymes, particularly in older patients, ENTOZYME effectively improves nutrition by bridging the gap between adequate ingestion and proper digestion. Among patients of all ages, it has proved helpful in chronic cholecystitis, post-cholecystectomy syndrome, subtotal gastrectomy, pancreatitis, dyspepsia, food intolerance, flatulence, nausea and chronic nutritional disturbances.

For comprehensive digestive enzyme replacement—

ENTOZYME®

Robins



From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



Case #2: This patient was a 34-year-old white gv 4, para 3, who was seen initially by her private physician in her second month of pregnancy.

Her prenatal course was uncomplicated and her past medical, surgical and obstetrical history was noncontributory. By menses she was due December 22, 1956. The patient entered labor spontaneously, with slight vaginal bleeding and was advised to go to the hospital, 1/4/57. On admission at 10:00 P. M. the nurse checked the patient and found the presenting part, vertex, was still high. The FHT were good, the cervix was one loose finger dilated. Her blood pressure was 110/70. About 9:50 A.M., 1/5/57 she began having hard contractions, examination revealed the cervix was thinning 3-4 fingers dilated. She had bled apparently 100 cc since admission. She was sedated with 100 mg of demerol, lcc of lorfan and 1/150 gr of scopolamine.

The membranes ruptured spontaneously around 10:00 A.M. Shortly after this she cried out complaining of pain in her chest. She felt dizzy, faint and became cyanotic though she was mentally alert and her blood pressure was 110/68. She continued having forceful uterine contractions.

She was taken to the delivery room and given O_2 and a small amount of cyclopropane and delivered spontaneously of a living 7 lb., 3 oz. girl with a midline episiotomy. The patient was in shock, had difficulty breathing, and had mucous rales in the chest especially over the entire left lung. The right seemed clear.

No blood pressure was obtained, blood was oozing from the uterine cavity. The cervix was checked and no visible tear was seen. The uterus was packed with gauze and bimanual pressure was applied for fifteen minutes. The uterus then seemed fairly firm.

It was observed that the patient had a large quantity of very dark amniotic fluid. The bleeding seemed controlled; however, she was typed and cross matched and 1000 cc 5% G/W was started. She was returned to her room at 11:45 A.M. with the vaginal bleeding controlled. She continued to receive nasal oxygen as she remained in deep shock.

Around 12:05 P.M. she was noted to continue to have a large amount of vaginal bleeding. Ergotrate, synkavite and adrenison were given and she was repacked with more gauze. She became irrational, tossing about and it became impossible to keep the needle in the vein. She received 100 mg demerol i.m. and a cut down was done on the left arm and blood was started. She continued to bleed vaginally and she expired at 1:30 P.M. three hours postpartum.

An autopsy was refused.

The cause of death was pulmonary embolus due to amniotic fluid and postpartum hemorrhage.

Comment

The Committee felt that this was a direct obstetric death probably due to a pulmonary amniotic fluid embolus or some similar vascular accident, in either event it was entirely unpreventable.

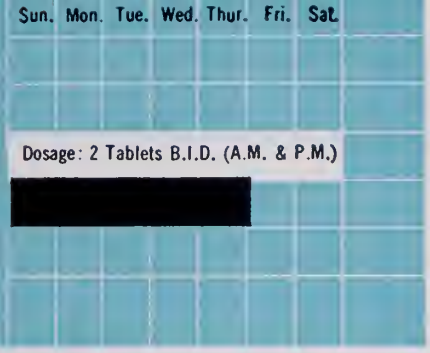
These cases were formerly called obstetric shock, or idiopathic postpartum uterine atony with hemorrhage. The diagnosis can be made by microscopic demonstration of meconium and amniotic fluid in the small pulmonary arteries, arterioles and capillaries. The clinical picture is sudden unexpected profound shock in a woman who is having unusually strong contractions or has just finished such a labor. Should pulmonary edema develop in the known absence of previous cardiac disease the diagnosis is reasonably certain. The patient cries from pain over the heart, gasps for air, becomes cyanotic and may die in a few minutes.

Fortunately it is a rarely encountered complication for there is little that can be done to help the mother. However, if the dilatation of the cervix is such that the infant can't be quickly delivered vaginally it should be delivered by a postmortem cesarean section.

Month of Pregnancy

	1	2	3	4	5	6	7	8	9		
									1	2	3
Blood pressure		110/70	110/68	102/64	108/64	110/68	118/70	112/64	116/70	116/70	118/76
Weight		120¼	121½	124½	128	133	137	139	143	143½	144
Urine		neg	neg	neg	neg	neg	neg	neg	neg	neg	neg

Rh+ VDRL non-reactive



in premenstrual tension only neo Bromth® treats the whole syndrome





It was the introduction of neo Bromth several years ago that created such widespread interest in the premenstrual syndrome—because of neo Bromth's specific ability to prevent the development of the condition in the first place.

The action of neo Bromth is not limited merely to control of abnormal water retention, or of nervousness, or of pain—or any other single or several of the multiple manifestations characteristic of premenstrual tension. neo Bromth effectively controls the *whole* syndrome.

neo Bromth is also completely free from the undesirable side effects associated with such limited-action therapy as ammonium chloride, hormones, tranquilizers and potent diuretics. neo Bromth has continued to prove to be the safest—as well as the most effective—treatment for premenstrual tension.

Each 80 mg. tablet contains 50 mg. Pamabrom, and 30 mg. pyrilamine maleate. Dosage is 2 tablets twice daily (morning and night) beginning 5 to 7 days before menstruation. Discontinue when the flow starts.

BRAYTEN PHARMACEUTICAL COMPANY • Chattanooga 9, Tennessee


No
turned-up noses
at this
new Erythrocin
suspension

a new derivative of Erythromycin designed especially for children

CITRUS-FLAVORED

ERYTHROCIN®

ETHYL SUCCINATE

ORAL SUSPENSION

Never a flavor like this in an antibiotic suspension. A new achievement in pharmaceutical elegance—a ready-mixed, stable suspension so sweet and good you can't tell it's "medicine."

No bitterness, no unpleasant aftertaste—just pure, sweet citrus flavor.

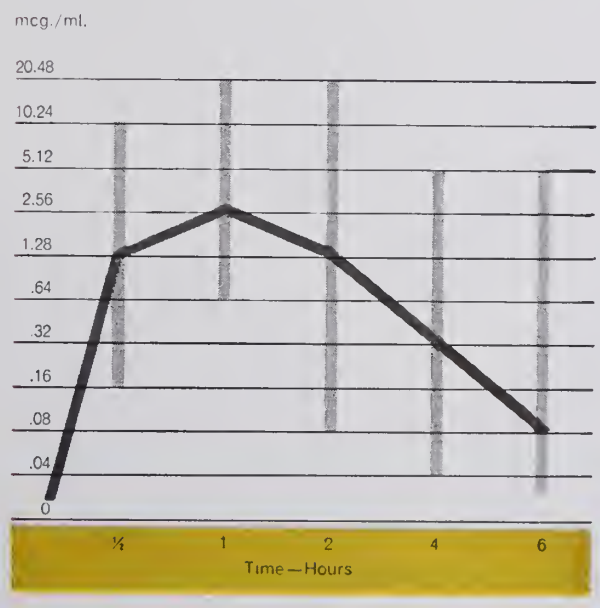
Never an antibiotic better proved against everyday coccal infections. After millions of prescriptions, an unparalleled safety record.

High, peak blood levels within one hour—plus nearly 100% effectiveness against coccal infections. And, unlike broad-spectrum antibiotics, ERYTHROCIN is classed as a bactericidal agent.

Indications: Against staph-, strep- and pneumococci. Especially useful when patients are allergic to penicillin or other antibiotics. **Dosage:** For children, 30 mg./Kg. per day. Adults, 1 to 2 Gm., depending on severity of infection. **Supplied:** In 60-cc., pour-lip bottles. Each 5-cc. teaspoonful represents 200 mg. of Erythrocin. Abbott

If you're concerned with blood levels . . .

Range of blood levels obtained from one dose of 400 mg. ERYTHROCIN SUSPENSION. Medication was administered to 30 volunteer adults, and represents a dosage of approximately 6 mg./Kg. Bars show ranges —continuous line indicates medians.



®ERYTHROCIN—ERYTHROMYCIN, ABBOTT 905105



WASHINGTON NEWS DIGEST



Washington, D.C.—The overriding health issue here —and one of the more debated subjects in any field —has been the dispute over radiation health hazards.

Out of the controversy, it is clear, will come a sharply stepped-up federal program of evaluating radiation levels, testing foods, and determining the effects of radiation on the human body.

Already, Arthur S. Flemming, Secretary of Health, Education and Welfare, has called for such an expanded program. And key congressmen are even more insistent that the government do more work in this area.

The growing concern over radiation levels and their effect on health has prompted harsh criticism of the Atomic Energy Commission by some lawmakers who contend the agency is minimizing radiation dangers because it handles the testing of nuclear bombs.

Agency officials claim they have held back no information from the public, but they agree on the need for a government-wide survey of the entire problem to determine how it might best be handled. At present, the AEC does the bulk of the research work on the biological effects of radiation.

The AEC and the Public Health Service have reported that the amounts of radioactive strontium-90 —the isotope that is released into the atmosphere by hydrogen bomb shots—have been far below estimated danger levels in food that has been tested.

However, Mr. Flemming has conceded that much more research has to be done. For example, he pointed out, little is known now about how much strontium-90 is retained within the body, though the amount consumed can be gauged.

A special advisory committee of 12 scientists and physicians that was appointed by the Health Service recommended after a year's study an exhaustive program of radiation research and protection as well as shifting prime responsibility from the AEC to the Health Service. The advisory group, headed by Dr. Russell H. Morgan of Johns Hopkins University, proposed also some sort of federal supervision over X-ray machines used by physicians.

Chairman Lister Hill (D., Ala.) of the Senate Labor and Public Welfare Committee has introduced legislation to carry out the advisory group's recommendations, and called for hearings on the measure.

Meanwhile, the National Academy of Sciences with the backing of the Administration, has undertaken a broad new investigation of the biological effects of radiation.

Notes

The House overwhelmingly approved the Keogh-Simpson measure to encourage retirement plans for the self-employed. Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee, promptly announced that he would hold hearings on the legislation this session. Last year, the Senate Finance Committee was unable to hold hearings on the measure since it passed the House too late in the session.

Rep. Aime J. Forand (D., R. I.), admitted that the future of his bill to provide government medical and hospital care as part of social security program is dark.

In a report to Congress, the American Medical Association noted "solid progress" in its program to improve the health care of the aged. Dr. Leonard W. Larson, chairman of AMA's Board of Trustees, said in a letter to the House Ways and Means Committee that the development of new insurance programs and expansion of existing lower cost protection for the elderly are moving forward "even faster than many of us would have dared hope only a few months ago."

The Defense Department's handling of the Medicare program providing treatment in civilian hospitals for qualified dependents of military personnel came in for some new congressional criticism. In a report accompanying an emergency money measure, the House Appropriations Committee said it was concerned with the "high costs" and believes "that little or no effort have been made to obtain reasonable rates for fees and expenses."

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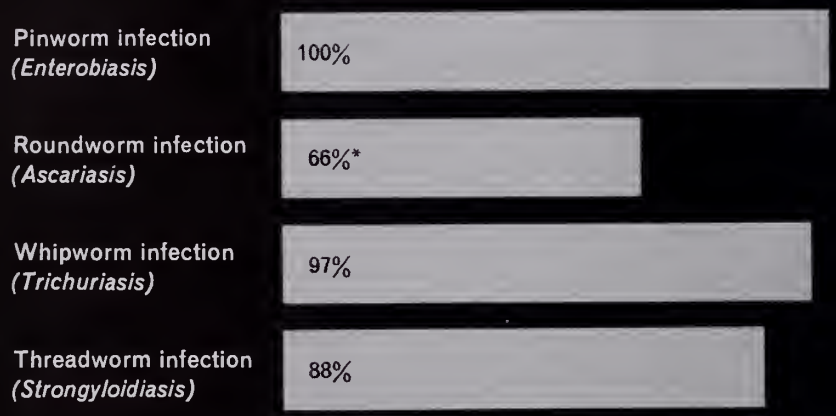
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1. Swartzwelder, J. C., et al.: J.A.M.A., 165:2063, 1957.

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Staphylococcal Pseudomembranous Enterocolitis*

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ABOUT four days after the institution of antibiotic therapy, usually a broad spectrum antibiotic, the devastating complication of staphylococcic enterocolitis may arise. Unless the condition is recognized and diligently treated, fatal outcome is almost a certainty.[1,2,3] The patient develops profuse diarrhea associated with shock and death may ensue within a few hours or days. A greenish appearance of the diarrheal stool may be the first indication of the complication. With the diarrhea there is extreme nausea and vomiting and marked abdominal distention due to the outpouring of fluid into the gastrointestinal tract. This brings about severe disturbance of water and electrolyte balance.[2,3] While these symptoms are typical, the syndrome may develop with only distention and shock and a very scant diarrhea.

If a smear and culture is taken of the diarrheal stool, staphylococci are found in great profusion and the diagnosis of "Staphylococcic Enterocolitis" is made.[1,4]

Infection alone is not enough to explain the symptoms of diarrhea and shock. The clinical picture is that of infection plus intoxication rather than infection alone and the symptoms in part are those of food poisoning.[5] This is the result of absorption of enterotoxin from the staphylococci.[4] The accompanying shock is therefore the result of the double onslaught of the loss of circulating and tissue fluid resulting in decreased blood volume and the generalized action of the staphylococci toxins. Anuria may develop from the shock.[5]

The tissue reaction taking place within the bowel is that of the formation of a fibrinous membrane containing leukocytes, colonies of staphylococci, exudate, and necrotic material.[6] This membrane usually involves the colon but may involve all or any segment of the gut including the stomach. Fragments of the membrane may be cast off in the diarrheal stool and may even be vomited.[1] Since the mucosa itself is mostly intact beneath the membrane it has been designated as a pseudo-membrane. Hence the name "Pseudomembranous Enterocolitis."

This disease, most often seen as a complication of antibiotic therapy, is known also to occur in patients who have had no antibiotics. Indeed, the disease was reported by Finney in 1893,[7] and Weismann and Twitchell[6] cite addi-

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tional references in the pre-antibiotic era.

The most frequent organism isolated in cases of pseudomembranous enterocolitis is Staphylococcus aureus, but this is not always the case. Dearing, Heilman and Sauer[4] studied forty patients who developed diarrhea following treatment with terramycin or aureomycin. Staphylococcus aureus was isolated from thirty-nine patients. Seven patients died and their death was attributed to the enterocolitis and not to the primary condition. There were six autopsies. Four showed pseudomembrane formation of the intestinal mucosa from which pure culture of Staphylococcus aureus was isolated. One case showed no membrane formation, but stool culture yielded staphylococci and death was felt to be due to staphylococcal enteritis. One case showed membrane formation, but culture at time of operation and at necropsy failed to reveal staphylococci. Single ante mortem stool cultures taken in nine cases of Weisman and Twitchell showed five in which the predominant organism was Staphylococcus aureus.[6] All were resistant to penicillin, streptomycin, aureomycin, and terramycin. One strain was found to be coagulase-negative.

Thus it appears that there is a definite entity of "Staphylococcal Pseudomembranous Ileocolitis," but also there are many variations on this disease. Also the benign diarrhea following antibiotic therapy may or may not be a fore-runner of this disease. That pseudomembranous enterocolitis may not always be caused by staphylococci is also apparent. Indeed, it would seem rather strange if staphylococci were the only cause of the disease, when one contemplates other disease entities which have multiple organisms as the etiological agents. However, from the literature few other organisms have been incriminated. Some cases have shown only the usual mixed flora.[8] The failure to find staphylococci in certain of the reported cases does not necessarily mean they were not present. In any bacteriological study an undetermined number of cultural failures is expected.

We may therefore conclude that whatever similar conditions lie outside the diagnosis of "Staphylococcal Pseudomembranous Enterocolitis" this diagnosis does most certainly embrace a clinical entity, one of which clinicians must be constantly aware. The problem is further enhanced by the increasing number of hospital induced antibiotic resistant strains of staphylococci.

The disease, while a definite entity, appears to occur as a complication, rather than a primary disease. It most often follows operative procedures on the gastrointestinal tract, but has been reported to occur in association with other conditions, such as pneumonia, genitourinary infection, peritonitis, and primary disease of the bowel which has not been operated upon.[5] The conditions in the bowel which allow the disease to develop whether occurring with or without antibiotic therapy are not entirely known. Van Prokaska, Long, and Nelson[9] have been unable to produce the disease experimentally in monkeys or kittens. This may not be significant when one considers that the natural resistance of most animals to staphylococci is considerably greater than that of man. These authors feel however, that some condition, known or unknown, destroys the coliform organisms in the bowel and allows the growth of staphylococci.

Here we might draw an analogy from nature. At certain times along the coastal waters of many parts of the world, conditions produced by unknown causes become favorable for the fulminant growth of certain marine micro-organisms known as dinoflagellates.[10] The explosive multiplication or "bloom" of these micro-organisms produce conditions known as red and yellow tides which are poisonous to fish and stinking windrows of dead fish may pile up along the beaches for as many as sixty miles. No unusual conditions are known to precede these "poisonous tides," but under the normal balance of nature, the growth of the dinoflagellate is kept in check. So it is in the bowel. The normal balance of coliform organisms is altered and the staphylococci which are constantly being carried to the stomach and the intestine find conditions where they "bloom" and the patient suffers the consequence.

Van Prokaska, Long, and Nelson[9] have formulated four postulates which cover the characteristics of this disease. These modified to the present bacterial nomenclature are:

1. Pseudomembranous enterocolitis is an infectious disease produced by Staphylococcus aureus.
2. Staphylococcus aureus does not establish itself in the intestinal tract containing the usual bacterial flora.

3. The shock and fatal course of the disease is enhanced by staphylococcal enterotoxin.
4. The effect of enterotoxin may be negated by the administration of corticotropin (ACTH), a lifesaving therapy.

Clinical Material

We have studied twenty-one cases of staphylococcus enterocolitis seen during a 2½ year period. There were seven deaths in which we have considered that the staphylococcal enteritis was at least contributory to the fatal outcome. This gives a death rate of 33% for this condition even when the diagnosis was promptly made and treatment begun. In all cases diagnosis was made by the finding of staphylococci in smears of diarrheal stools as soon as diarrhea was recognized. The finding was confirmed by a culture in every case. Staphylococcal enterocolitis occurred as a complication in the treatment of some other disease which was most always of serious nature. The complication occurred in ages 2 to 76 and it might be noted that the 2-year-old suffered the complication twice, each time during the course of treatment for tuberculous meningitis.

The complication most frequently occurred in the treatment of diseases of the gastrointestinal tract which included carcinoma of the esophagus, gastric and duodenal ulcer, obstruction of the small intestine, obstruction of the large intestine, ruptured appendicitis, carcinoma of colon, diverticulitis of the colon, chronic ulcerative colitis, carcinoma of the gallbladder, chronic cholecystitis with stones, and carcinoma of the pancreas. The disease also occurred during the treatment of lymphosarcoma, tuberculous meningitis, congestive heart failure, pneumonia, kidney disease, and generalized vascular disease. All of our cases have followed the use of either broad spectrum antibiotics or combinations of antibiotics.

Treatment

Effective treatment depends upon early diagnosis followed by immediate instigation of therapy. When staphylococci are found in the smears of the stool, cultures should of course be started, but treatment should not be delayed until the report of cultures and sensitivity. If the patient is receiving an antibiotic at the time the diagnosis is made, this antibiotic should be discontinued and the patient should receive instead one of the antibiotics known to be effective against the organism. It is essential that the antibiotic be given by the oral route in order to obtain the maximum concentration of the agent in the lumen of the intestinal tract.[1] Of first choice among antibiotics is erythromycin,[5, 10, 11, 12] unless the patient was on this drug when the complication commenced. One of the newer antibiotics such as ristocetin, novobiocin or vancomycin, may be indicated if the organism is resistant to erythromycin. Fluids, electrolytes, blood plasma, and serum albumen are forced to combat the constant loss of fluid from the bowel and to combat shock. Up to 12 liters a day of total fluid may be required.[1] Corticotropin (ACTH) is reported to have dramatic effect against the toxic effects by some authors and denied by others. ACTH has not been used in this series.

Summary

Staphylococcal pseudomembranous enterocolitis is a serious complication of antibiotic therapy in our hospitals today. During the past 2½ years we have had occasion to observe twenty-one cases of this disease. The mortality rate was 33%. Improvement in the mortality of this disease will occur with early recognition and diagnosis combined with vigorous treatment. At the present time erythromycin is effective in the treatment of most cases. In the rare instance of staphylococci resistant to erythromycin, one of the newer antibiotics such as novobiocin or vancomycin may prove effective.

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Acute Nonsuppurative (Subacute) Thyroiditis

A Report of Two Cases

Treated With Triamcinolone and Prednisolone

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ACTH and Cortisone have been recommended and successfully employed in a long list of disorders since the early years of this decade. In 1951 they were tried with success in acute nonsuppurative (subacute) thyroiditis. Some 5 years later one writer[1] could find only 18 published cases in which steroids had been used in this manner. A prompt and dramatic response has been consistently reported.[2, 3, 6, 10] This communication describes the result of steroid therapy in two patients, seen in office practice, in whom triamcinolone (Aristocort®) and prednisolone (Delta-Cortef®) were used.

Subacute thyroiditis chiefly affects females 30 to 50 years of age. Histological changes within the thyroid are characterized by epithelial destruction and giant cell proliferation without suppuration. Crile[4] has recommended needle biopsy in questionable cases but this was not deemed necessary in my two cases. Inflammatory changes are believed responsible for the release of stored colloid which elevates the protein bound iodine in the blood. The reduced uptake of I_{131} by the thyroid and its increased urinary excretion is attributed to the inflammatory exudate which injures acinar cells within the thyroid follicles. Thyrotrophic stimulating hormone circulates in reduced amount. The BMR may be normal or elevated. The sedimentation rate is increased. The disease can simulate an acute infection. Sore throat, malaise, muscle aching and fever are the usual constitutional complaints. Neck pain coincides with enlargement of the thyroid and characteristically is referred to one or both ears. Ear pain may disappear only to reappear as the inflammatory process spreads to involve a new and larger area of the gland. As both the etiology and pathogenesis of subacute thyroiditis remain unknown, diagnosis is made on its clinical features. Palpation of the thyroid in all patients suffering with the ubiquitous symptoms listed above will be rewarding to the physician and decisive in patient management should enlargement of the gland be found by this simple examination. Untreated, the disease may persist for months. Steroids, when properly employed, will induce a remission in days.

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Case #1

A 53-year-old white female presented herself on Sept. 19, 1958 complaining of weakness and fever. For the past 6 months she had not felt up to par. She attributed this to numerous extractions done at that time for pyorrhea alveolaris. On August 28, 1958 she developed a sore throat and fever. Her physician prescribed a penicillin-sulpha preparation from which she failed to benefit. One week later she was hospitalized for 4 days with fever as high as 103°, but again failed to improve. An inconstant and recurrent aching in the right ear was felt at times during this period. Every

day her temperature would mount to between 101° and 102°. She developed nervousness, exhaustion, night sweats and a loss of 10 pounds in body weight.

Examination revealed a middle aged woman in no acute distress but whose appearance suggested chronic disease. The temperature measured 98.4°, the radial pulse 120 per minute, respirations 18, B. P. 110/70. With the fingers extended a fine tremor was visible in both hands. The thyroid was grossly enlarged with some nodularity in both lateral lobes. The gland was tender, tense and painful to examination. Neither a thrill or bruit was found over the gland. The heart was normal in size and shape. The rhythm was regular, the rate rapid. No significant murmurs were heard. All reflexes were slightly hyperactive. The rest of the examination was normal.

The hemoglobin measured 9.0 grams and the red blood count 3.3 million per cu. mm. The white blood count totalled 4,850 with 60% polys, 36% lymphs., 3% eosin., 1% mono. The sedimentation rate was 32 mm. in one hour. Urinalysis was normal throughout. The BMR was plus 26. A protein bound iodine was reported as 9.5 mcg.%. The VDRL was nonreactive. An ECG revealed sinus tachycardia without electrocardiographic evidence of myocardial disease. A chest film exposed at 6 feet was interpreted as normal.

Triamcinolone was administered as 4 mg. tablets 4 times a day. On the third day the thyroid was smaller, softer and painless. Fever had disappeared. On the seventh day the drug was reduced to 2 mg. q.i.d. and discontinued on the tenth day. Concurrently 1600 mg. of meprobamate was administered daily. One month later the BMR was minus 5. For the present this patient has no complaints and remains euthyroid.

Comment: This case history demonstrates many of the classical features seen in subacute thyroiditis. At the onset sore throat and fever suggested infection. Thyroid involvement was followed by right ear pain which would come and go. The rapid pulse, tremor and the elevated BMR resulted from insult to the thyroid with the escape of stored colloid to the circulation, raising the PBI level into the thyrotoxic range. Antibiotics completely failed to control her disease. Dramatic improvement followed the use of triamcinolone. Her thyrotoxicosis as expected was transitory and short lived.

Case #2

A 48-year-old white female sought medical consultation on 4-18-56 complaining of a swelling in the neck and painful swallowing. For the past 10 days she had suffered with what she called a cold. On 4-13-56 she noticed swelling in the neck, pain in both ears and pain over both supraclavicular areas. She denied fever. Mild headache and night sweats had been present since the onset.

The important findings on physical were limited to the neck. The thyroid was twice its normal size. A nodule in the right lobe found on an earlier physical was enlarged out of proportion to the rest of the gland. The ears were normal. The supraclavicular areas appeared normal. Neither myxedema or thyrotoxicosis was found from the evidence collected from the physical examination. All other findings were normal. All laboratory studies including a BMR and PBI were reported as normal.

Prednisolone in the dose of 30 mg. was administered daily for 72 hours. This was followed by 20 mg. daily for 3 more days. A total of 150 mg. was given over a 6-day period when the drug was stopped. Improvement was seen immediately. In 4 weeks the BMR was minus 13. Eight weeks later the BMR was minus 7. Today the patient is well and remains euthyroid.

Comment: In comparison with case #1 this patient suffered a mild attack. Evidence of thyrotoxicosis was not found. Pain however was referred to both ears and both supraclavicular areas which suggests diffuse involvement. A nodule in the right lobe found one year before on routine physical appeared to be a special target for the disease. The results with prednisolone are considered impressive considering the brief period of treatment.

Discussion

Subacute thyroiditis, known by a variety of names including De Quervain's Disease, subacute non-purulant thyroiditis, giant cell thyroiditis and pseudotuberculous thyroiditis is a distinct clinical entity. It is unfortunately true that many cases go unrecognized.[2] As spontaneous recovery after weeks or months can be predicted in most cases, tissue for pathological study is rarely obtained. It is for this

reason that most surgeons and pathologists have had limited experience with these cases. The physician on the other hand can successfully treat subacute thyroiditis without subjecting the patient to a surgical procedure. Needle biopsy is seldom required if an adequate history and physical is done. In addition the limitations of needle biopsy are appreciated and as emphasized by Gunnel[6] the diagnosis in our present state of knowledge must remain clinical rather than rest on the typewritten report of the pathologist. The pitfalls of cytologic diagnosis in this disease are widely known and generally recognized.

During the acute stage, discrete and isolated areas in the thyroid exhibit an exudate which contains plasma cells, lymphocytes and polymorphonuclear leukocytes. Many acinar cells within the thyroid follicles are destroyed. Distinctive, large, multinucleated cells appear which are considered characteristic. As the exudate recedes fibrosis appears. Should fibrosis be extensive the gland becomes indistinguishable from Riedel's Struma. Microscopic abscesses are said to occur but gross suppuration has not been described. In severe cases with extensive destruction one might expect myxedema to follow. Myxedema according to Barr[12] is not seen after subacute thyroiditis. He points to subtotal thyroidectomy, in which 95% of the gland is often removed and the remaining portion, small as it is, is able to maintain many patients in a euthyroid state. Neither inflammatory destruction or subtotal surgical ablation diminishes the latent proliferative and regenerative powers of the thyroid. This capacity to maintain a normal level of hormone production in the face of extensive loss assures a euthyroid state in these cases. Thyrotoxicosis has followed subacute thyroiditis[8] but a direct relationship has not been established.

Werner[9] estimates 1% of all thyroid disorders are due to subacute thyroiditis. Barr[12] states it to be the commonest cause for painful swelling of the gland. The disease may be insidious or explosive in its onset. Chills, fever, sore throat, malaise or muscle aching may be the presenting symptoms. Fever is said to be absent in most cases.[9] Neck pain referred to the ears has been alluded to. Pain of thyroid origin is also referred to the back of the neck, the supraclavicular areas and down the arms. Coughing, swallowing or motion of the head may be painful.

Czerniak and Harell-Steinberg[5] have reported their results in 10 untreated cases, all of whom became euthyroid within 8 months. Their studies with radio-active iodine showed a reduced thyroid uptake and an increased urinary excretion during the acute stage. When thyrotrophic stimulating hormone was given a temporary increase in the uptake of I_{131} could be demonstrated. When TSH was stopped the uptake fell to the original low level. Months later all 10 cases returned to the normal uptake range.

The two patients that make up this report point up the wide range in symptoms encountered in subacute thyroiditis. Both patients responded to steroid therapy. The advantages claimed for the newer steroids are sufficiently well known not to require elaboration. No side effects resulting from triamcinolone or prednisolone were noted and both patients enjoyed the prompt relief that followed their use. The hazards of their use, a limiting factor in the treatment of other disorders, is of no real consequence in subacute thyroiditis, as the remedy is given for a short time only.

Conclusions

This report confirms the published work of others who have employed steroids in subacute thyroiditis. Triamcinolone and prednisolone, two of the newer steroids, gave satisfactory results when similarly employed. The pathology and altered physiology of the disorder have been briefly described.

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A Review of the Management of Chronic Ileo-Colitis

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CHRONIC regional enteritis is a benign, usually granulomatous disease that most often attacks the small bowel.[2] Certain studies, however, include a remarkable incidence of involvement of the large intestine either regionally or diffusely. The occurrence of regional enteritis discovered in the colon by surgical operation or autopsy has been variously estimated from 40 to 55%.[5, 7, 9] The involvement of the colon by regional enteritis is not to be confused with "back wash ileitis" which is observed in 20-25% of cases of chronic ulcerative colitis.[10] "Back wash ileitis" is thought to result from reflux of infected bowel contents into the small bowel.[1] The terminal ileitis seen in chronic ulcerative colitis is not usually associated with fistulization, aboral spread, or skip areas.

In approximately one-third of the cases with colon involvement, there is granuloma formation. In the remaining cases a chronic ulcerative or exudative lesion which is pathologically indistinguishable from ulcerative colitis is noted. In a recent survey of cases reported from the Massachusetts General Hospital the colon was found to be involved in some way by regional enteritis in 43% of 126 cases.[5] Changes consistent with regional enteritis were found in the cecum and ascending colon in 39 cases, in the tranverse colon in 5 cases, in the descending colon in 5 cases, and in the sigmoid in 6 cases. In 14 cases of that series diffuse ulcerative changes in the colon were documented three weeks to nineteen years after the onset of regional enteritis in the small bowel.

Yarnis, Marshak, and Crohn have reported 64 cases of chronic ileo-colitis, 45 of which occurred simultaneously with the onset of regional enteritis and 19 cases in which the colon became involved after the dated origin of the regional enteritis.[12]

There seems to be some relationship between regional enteritis and ulcerative colitis but this association has never been clarified.[11]

Chronic ileo-colitis is infrequent but is by no means rare. It appears that there is a preponderance of cases on the eastern seaboard but this may be more apparent than real, for recently van Patter reported 600 cases of regional enteritis from the Mayo Clinic and of this group the colon was involved in some way in 41%.[9]

The spontaneous remission rate in chronic regional enteritis has been reported as 1-2% but 0% for chronic ileocolitis.[5] This lack of remission in chronic ileo-colitis reflects a more virulent form of the disease and should lead to skepticism when evaluating cases of spontaneous remission. The recurrence rate in chronic ileo-colitis following all types of treatment has ranged from 40-60%.[5, 6, 9, 12] There appears to be a higher incidence in the young age group. In the Mt. Sinai series of 64 cases the mean age was 26.5 years with a slight preponderance in males.[12] No ethnic relationship could be established.

Diagnosis

The diagnosis of chronic ileo-colitis frequently stems from the physicians' association of abdominal symptoms with the disease. The clinical picture usually includes a low grade fever, right lower quadrant or hypograstric colicky pains, diarrhea, and weight loss. The presence of a right lower quadrant mass, fistulization, or perianal disease coupled with the aforementioned symptoms in the young patient suggest regional enteritis. Diarrhea in excess of four stools a day implicates the colon. It seems that as soon as the colon becomes incorporated in granulomatous and/or ulcerative lesions, the diarrhea changes from the guaiac negative, foul, mushy 2-4 stools a day of regional enteritis to the 10-20 watery, stringy, guaiac positive, stools more characteristic of

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ulcerative colitis. It is generally conceded that the more caudad the colon is involved the greater will be the number of stools.

The chronicity of the complaints should steer one away from appendicitis and suggest the necessity for sigmoidoscopy and radiological examination of the entire gastrointestinal tract. It is important to perform a sigmoidoscopy to establish the presence or absence of rectal disease. A barium enema will give some idea of the status of the colon and perhaps the terminal ileum. It is mandatory to secure a small bowel motor meal so that intestinal motility is evaluated and skip areas are not overlooked. The above sequence in diagnostic procedures appears logical.

Complications

From the following selected series it is most apparent that the natural history of chronic ileo-colitis, whether or not altered by treatment, is beset by frequent complications. Some knowledge of these complications often salvages the chronically ill patient.

Complications in 14 cases of regional enteritis and diffuse colitis:[6]

Table I

Internal fistula	2 cases
Rectal stricture	1 case
Anal fistula	2 cases
Hemorrhoids	2 cases
Hypochromic anemia	9 cases
Erythema nodosum	2 cases
Perianal abscess	5 cases
Rheumatoid arthritis	2 cases
Wound fistula	2 cases
Dehiscence	1 case
Wound sepsis	2 cases
Volvulus of small bowel	4 cases
Ileostomy dysfunction	3 cases

Complications in 64 cases of chronic ileocolitis:[12]

Table II

Duodenal ulcer	7 cases
Rheumatoid arthritis	18 cases
Tetany	3 cases
Fecal fistula	17 cases
Erythema nodosum	17 cases
Clubbing	4 cases
Splenomegaly	6 cases
Abdominal mass	26 cases
Rectal complications	25 cases

Management

X-ray evidence of ileo-colitis is inadequate grounds for surgical intervention. Unless definite complications force the hand of the surgeon, the patient is managed by an aggressive medical program. Frequent office visits and occasional periods of hospitalization may be mandatory to arrange the best supportive regime for the patient. This disease is not distinctly a medical or surgical problem but requires close cooperation between the medical man and the surgeon. Failure to invoke the team work concept in the management of this disease will result in too much conservatism on one hand or ill timed surgical intervention on the other. Either approach in chronic ileo-colitis is at the expense of the patient.

The indications for surgical intervention are hemorrhage, perforation, obstruction, fistulization, incapacitating eye or arthritic changes, intractable rectal sepsis, abdominal mass, and possible malignant degeneration.

I have been able to find only one report of a malignancy associated with regional enteritis,[9] but in view of the occurrence of carcinoma in ulcerative colitis it is wise to be aware of this potential hazard.[4]

The medical program consists of bed rest, a bland, low residue, high calorie diet, antispasmodics, intestinal antibiotics, and mild sedation. Steroids, especially Acthar Gel,® may be tried but have proven more beneficial with the ulcerative process than with the granulomatous lesions. However, the sense of well being and improvement in appetite produced by the steroids are no small assets even in granulomatous regional enteritis. In prescribing intestinal antibiotics one must be mindful of the possibility of staphylococcal enteritis if wide spectrum antibiotics are employed for long periods of time. Vitamin deficiencies must be corrected. Crohn has advocated the use of vitamin B-12 if malabsorption is suspected from bulky, fatty stools[3] or a blind loop is known to exist. Symptomatic blind loops must be resected.

In view of the known recurrence rate of 40-60% no matter what type of treatment is

adhered to, the following indications are reiterated: hemorrhage, perforation, osbtruction, fistulization, abdominal mass, intractable rectal sepsis, questionable malignancy, incapacitating eye complications and rheumatoid arthritis. It seems unwise to think of chronic ileo-colitis as a simple variant of regional enteritis. Even though the disease belongs in the same general category, it usually appears more virulent, with more disabling features. This becomes especially true if the entire colon is involved. There is no question that the lesion or lesions in the gastrointestinal tract must be considered simultaneously. In practice the treatment of chronic ileo-colitis seems to be handled best by attacking primarily the colon lesions. Again this becomes especially applicable in diffuse colon disease.

Resection is favored in cases of chronic ileocolitis because of the lack of remission of colon disease following short circuiting procedures. The severity of the complications such as massive hemorrhage or fistulization into the bladder, sigmoid, or duodenum also make resection more desirable.

If the disease is confined to the terminal ileum and right colon, a right colectomy, terminal iliectomy, and ileocolostomy are favored. A subtotal colectomy, ileosigmoidostomy and terminal ileectomy are elected if the terminal ileum and large bowel are involved but the sigmoid is free of disease. A terminal ileectomy, subtotal colectomy, and ileostomy are chosen if the terminal ileum and entire colon are involved. Ulcerations in the sigmoid stump prohibit anastomosis because of the likelihood of perforation or future stricture. An abdomino-perineal resection may be elected if the ano-rectal disease is severe but it is left to a later time, if possible, because impotence in males may be produced by injury to the pre-sacral nerves. Of 26 males having abdomino-perineal resection for ulcerative colitis, Stahlgren and Ferguson reported impotency in 5 cases.[8]

No effort is made to do a radical resection at the time of exploration for this is a benign disease and there is no evidence which supports wide removal of the lymph nodes.

Ulcerative ileo-jejunitis complicated by regional or diffuse colon disease is a most difficult problem. Malabsorption as a result of ileo-jejunitis and the diarrhea from colon involvement often lead to a tragic end. Surgery has usually been disappointing in this group and only in the face of hemorrhage, unrelenting obstruction, bladder, sigmoid, or duodenal fistulization or perforation is surgery contemplated. Once surgery is considered it frequently becomes a prodigious undertaking in a most depleted patient. Massive resection is usually ill advised. It is in this ulcerative ileo-jejunitis and colitis that the steroids have been most effective.

Certain technical features should be mentioned. At the time of surgical exploration the entire gastrointestinal tract from stomach to pelvic floor must be carefully examined. The site chosen for anastomosis or ileostomy must be at least 12 inches proximal or distal to the diseased segment. Anastomosis must be done carefully no matter whether an end to end or side to side type is chosen. This becomes evident when evaluating recurrences at the anastomosis. Two-thirds of the supposed recurrences may be due to stricture formation.[5]

If skip areas are present they must be considered in the overall management of the problem. Skip areas in the small bowel may be short circuited by complete exclusion or resected with about equal results. The concept of shunting with exclusion, however, does not seem to apply with similar results when the disease involves the large intestine.

Results

14 cases of regional enteritis and diffuse ulcerative colitis from the Massachusetts General Hospital;[6]

Table III

Subtotal colectomy and ileostomy—6 cases		
Good	3	
Fair	2	
poor	1	death
Subtotal colectomy and ileo sigmoidostomy—3 cases		
Good	2	
Fair	1	
Poor	0	
Ileo tranverse colostomy with division of small bowel —3 cases. Treated only for regional enteritis of small bowel.		
Good	0	
Fair	0	
Poor	3	

Patients were followed 8-20 years but results were based on two to three years follow-up after surgery and patients were graded good to poor on basis of work capacity and symptoms. None of these patients could be managed by medical therapy alone.

Yarnis, Marshak, and Crohn employed medical therapy in 18 out of 64 patients with chronic ileo-colitis. Three cases are well, 5 cases improved, and 8 patients are poor with recurrence. In 46 surgical cases the results were good in 12 cases, 8 improved, 21 poor, 2 deaths, and 3 lost to follow-up. Fourteen cases required ileostomy.[12]

Best results have been obtained in cases in which the disease was confined to short continuous segments of terminal ileum and right colon. If the colon becomes involved following the onset of regional enteritis of the small bowel, the course of the disease is apt to be severe and unrelenting. If surgical therapy is productive of good results for one year, the outcome is likely to be favorable but recurrences have been reported after twenty years of quiescence of regional enteritis.

Summary and Conclusions

(1) Regional enteritis which is characterized by a benign, granulomatous or ulcerating lesion, although usually confined to the small bowel, may involve both large and small bowels in 40-55% of the cases.

(2) The spontaneous remission rate in chronic ileo-colitis is 0% in contrast to regional enteritis confined to the small bowel which has a spontaneous remission rate of 1-2%. The recurrence rate in chronic ileo-colitis is 40-60% no matter what type of treatment is employed.

(3) The diagnosis is suggested when crampy abdominal pain, weight loss, diarrhea, anemia, and fever are associated with right lower quadrant mass, perianal sepsis, and fistulization in the young age groups. Sigmoidoscopy, barium enema, and small bowel motor meal are helpful in confirming the diagnosis.

(4) The change in the number of diarrheal stools from 2-4 to 10-20 suggests colon involvement.

(5) X-ray demonstration of chronic ileo-colitis is no indication for surgical intervention unless such complications as perforation, hemorrhage, obstruction, fistulization, abdominal mass (interpreted as partial obstruction and/or fistulization), intractable rectal sepsis, severe rheumatoid arthritis, eye complications, or questionable malignant degenerations are present.

(6) Resection rather than exclusion by short circuiting is favored in view of the high recurrence rate and the severity of the complications. The complications appear to be relieved more satisfactorily by resection. Even with complete exclusion the disease may not become quiescent.

(7) Resection gives the best results in cases in which the disease is confined to the terminal ileum and cecum or ascending colon. Diffuse colon involvement will usually require an ileostomy and colectomy. If the distal sigmoid and rectum are free of disease, a subtotal colectomy and ileosigmoidostomy are chosen. Diffuse small and large bowel involvement from extensive ulcerative lesions is best managed with medical therapy utilizing the steriods.

(8) Absence of recurrence for a year following definitive surgery may represent a cure but recurrences have been noted as late as 20 years following surgical procedures.

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Management of Benign Adenomatous Polyps of Rectum and Lower Sigmoid*

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A study was made of one hundred patients with benign polyps of the rectum and lower sigmoid. Only fulguration was used to destroy the benign polyp in each patient. A method of treatment for benign polyps is presented which may be easily utilized by a physician in general practice.

Various cancer detection centers report 2.8 to 15 per cent as the incidence of rectal polyps found at routine proctosigmoidoscopy in normal asymptomatic patients. The percentage is even higher in those who have complaints referable to the colon.

Digital examination and proctosigmoidoscopy are effective in the early detection of cancer and premalignant lesions such as benign adenomatous polyps. Approximately seventy-five per cent of cancers of the large intestine are in the sigmoid and rectum and approximately seventy per cent of the benign polyps occur in this region. Benign adenomatous polyps of the rectum and colon occur in both sexes and appear at all ages with increasing incidence beyond thirty-five. Buie[3] has stated that probably twelve to fourteen per cent of persons more than forty years of age have polyps in the colon and that one out of every ten of this age group has a polyp which can be discovered on proctoscopic examination. All polyps should be destroyed immediately. All polyps of the colon are cancers or will become cancers if they are not destroyed and if the patient lives long enough.

Familial polyposis and pseudopolyposis associated with ulcerative colitis and other inflammatory diseases of the large intestine are excluded from this discussion. Hypertrophied anal papillae and submucosal tumors are also excluded because they constitute a different type of lesion.

Proctosigmoidoscopy should be a routine in every general physical examination in patients over forty years of age. A barium enema with air contrast study should be recommended whenever a polyp is found.

Material and Method

In the section on proctology at the Lexington Clinic, a study was made of one hundred consecutive cases in which fulguration was used to destroy polyps. For each patient a record was made of the gross appearance of the polyp as to its size, location, color, type, and whether pedunculated or sessile and if fixation, induration, infiltration, ulceration or obstruction was present. A small rough pencil drawing was also made of each polyp found. A routine barium enema with an air contrast study was performed in every case, except for three patients who refused this procedure.

A statistical study was made to determine (1) the number of polyps found in the rectum, (2) the number in the sigmoid, (3) the number with recurrence, (4) the number of patients with a negative x-ray of the colon, (5) the number of patients with an x-ray of the colon showing polyps in other parts of the large intestine, (6) the number of patients with a malignancy in other parts of the colon, (7) the number of patients with multiple polyps seen through the proctoscope, (8) the number of patients in whom polyps were later found on re-examination in areas other than that from which the original polyp had been removed by fulguration, and (9) the number of patients with heredofamilial polyposis. The findings will

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be given under results.

Management of Polyps

Buie and co-worker[3] and Jackman[10] consider that fulguration plays an important part in the treatment of polyps of the terminal portion of the colon but that much care should be exercised in determining when it should be employed. A proctoscope suitable for performing fulguration includes a built-in suction tube through which smoke and gas can be exhausted from the intestine. If such suction is not available gas within the intestine may ignite and explode. Means must also be provided for exhausting stools and fluids from the intestine with a suction apparatus. The surface of the lesion should be kept dry.

The term fulguration as employed in this paper designates a procedure intended to destroy growth by means of an electric spark which emanates from the electrode of a monopolar curent. It is best while fulgurating to hold the tip of the electrode so that a small spark will leap approximately 5 or 6 mm. from it to the surface of the growth. Fractional fulguration may be necessary at indefinite periods to destroy larger polyps.

In general, the management of benign polyps of the rectum and lower sigmoid may be divided into the following outstanding points.

LOCATION: Polyps on the posterior wall of the rectum are the most suitable for fulguration because that wall is not covered by peritoneum. Because of the level of the peritoneal reflection polyps on the anterior and lateral walls of the rectum require more consideration before fulguration. When fulgurating a polyp on the anterior wall one should constantly bear in mind the proximity of the vagina, the uterus, the urinary bladder, the seminal vesicles, and the prostate gland. The best location of a polyp for fulguration is the posterior wall of the middle portion of the rectum or the lower part of the rectum just above the anorectal line.

One should notice whether the polyp is above or below the peritoneal reflection before starting fulguration. Many physicians keep in mind the oldtime rule that the peritoneal reflection is usually about 5 cm. above the anorectal line in males and about 3 cm. in females. When a polyp is located above the peritoneal reflection, one should be very cautious in the use of fulguration. Polyps below the peritoneal reflection may be fulgurated without undue danger. If a benign polyp is on the posterior wall above the peritoneal reflection it may be destroyed without much danger. If a small adenomatous polyp is in the lower sigmoid and on the anterior or lateral wall it may be destroyed by cautious fulguration. No polyp in the lower sigmoid should be fulgurated unless one can easily reach the base of the polyp and pass the proctoscope beyond it. It is best to hospitalize the patient before fulguration if the polyp is more than 2 cm. in diameter and is located above the peritoneal reflection.

If the above 2 cm. polyp on biopsy showed an inconclusive histological report it is best to remove it by abdominal surgery and not fulguration. Hemorrhage and perforation are undesirable complications and should be avoided by care and by following the above suggestions. The management of polyps above the lower sigmoid will not be discussed in this paper since these cases are referred to our general surgeons.

SHAPE AND SIZE OF THE POLYP: One may fulgurate small sessile polyps with little regard to their position in the intestine and this was done at the time of our first proctoscopic examination. Small sessile polyps as large as 6 to 8 mm. in the diameter were fulgurated in the mobile portion of the sigmoid but extreme care was taken to prevent any destruction in the wall of the intestine which might result in perforation. The larger sessile lesions were fulgurated on the posterior wall of the lower two-thirds of the rectum. It is felt that this can be done without any particular danger as long as the polyps are on the posterior wall and below the peritoneal reflection. When the polyp is pedunculated rather than sessile the situation is more favorable. The pedunculated or elongated polyps were fulgurated regardless of size (that is, less than 5 cm. in diameter) if the location afforded adequate exposure of the polyp and the entire pedicle. In those cases in the lower sigmoid where the polyp and the base of the pedicle could not be easily seen, no fulguration was attempted. The case was referred to the general surgical section in the Lexington Clinic for removal of the polyp through the abdominal route.

Those cases in which there was a large polyp involving a large area of rectal mucosa and showing considerable hyperplasia were also re-

ferred to the general surgical section for more radical treatment. It has been noted by numerous authorities that the recurrence rate and the incidence of malignancy increase in the larger polyps.

The larger polyps are more dangerous. They may be of an adenomatous character or of a low grade malignancy. Although they tend to remain inside for longer periods without undergoing metastases, one must treat them surgically and not by fulguration. It has also been noted that ulceration, nodular irregularity, and a broad pedicle or base suggest malignancy. Firmness, induration, and fixation to palpation are definitely malignant characteristics. Therefore, a polyp with those qualities should not be fulgurated unless radical surgery is refused completely or pulmonary or cardiac or general disability prevents the use of surgical measures.

FIRMNESS AND FIXATION: By careful manipulation of the sigmoidoscope or with the index finger when the polyp is within reach, one can often determine whether the polyp is firm or soft and whether it is freely mobile. If the polyp feels hard or firm and especially if it is fixed, the examiner should consider the greater likelihood of malignancy and advise against fulguration.

CONDITION OF MUCOUS MEMBRANE NEAR POLYP: When the examiner observes any inflammation or hyperplasia of the mucous membrane next to a small polyp it should be a warning sign that new polyps are likely to occur and that more frequent observation is necessary after fulguration.

BIOPSY: The advisability of routinely obtaining a biopsy on all polyps regardless of size has been debated on numerous occasions. Nesselrod[16] and Buie[3] and others feel that it is not usually necessary to do a biopsy on the small polyps which are usually routinely destroyed at the time of the first examination. Nesselrod[16] feels that there is no security to be gained from a negative biopsy and that the chances of picking up the malignancy in the tiny piece of tissue removed are small.

Buie[3] has very aptly stated that the progress of histologic metamorphosis in all polyps of the colon is so certain that all the polypoid lesions of the colon, even when not actually classified as malignant growths, should be treated as such. Whenever possible they should be destroyed promptly on discovery.

It has been my policy to destroy by fulguration all of the tiny polyps whether sessile or pedunculated without a biopsy. No malignancy has been found in the follow-up on these cases.

I have felt that if the polyp is larger, a biopsy can be done without danger of perforation of the intestine and enough tissue for adequate study can be presented to the pathologist.

Some authorities feel that the malignancy begins in the periphery or the tip of the polyp. However, this is not always certain. One should think carefully as the malignancy may be in the pedicle of the polyp. It is often best to excise the entire polyp or take several biopsies from the firmest area near the base of the polyp in order to get a good specimen for study.

Review of Literature

This study does not include the management of malignant polyps of the rectum and lower sigmoid but it was felt best to review briefly the most recent opinions in this regard. Whenever a polyp is found the question whether it is malignant or benign arises.

Swinton[20] stated that a polyp is malignant if any two of the following three features are present on microscopic examination of the biopsy material: (1) anaplasia, (2) irregular architecture or (3) invasion. Many others including Helwig[8] and Buie[3] and others adhere to the Borders classification of malignancy which is based on the degree of cellular anaplasia. This classification was also used in deciding whether to use conservative measures such as fulguration or radical surgery in the series here presented. Klein and Scarborough[13], Lahey[14], and Bacon and Peale[2] feel that adenocarcinoma is present only when there is microscopic evidence of invasion beneath the muscularis mucosae and that radical surgery is necessary when there is such evidence.

Lahey[14], Scarborough and Klein[19], and McLanahan, Grove and Kieffer[15] in accepting invasion as the only dependable feature of microscopic determination of malignancy expressed the belief that all malignant lesions occurring in polyps should be treated by radical surgery.

Fisher and Turnbull[21] have said that certain carcinomas arising on colonic polyps may be managed successfully by conservative therapy without reducing the chances for cure.

Ackerman[1] recommended local excision or segmental resection as the treatment of choice when the polyp has a well defined stalk and carcinoma is present in the end of the polyp.

Castro. Ault and Smith[4] fulgurated twenty-one lesions that were the site of malignant change; thirteen have not recurred after more than one year and nine had not recurred after more than five years.

Complications of Fulguration

The complications to be avoided in fulgurating a polyp are perforation and hemorrhage. The level of the polyp in relation to the peritoneal reflection should be considered carefully. Above this reflection the intestinal wall is thin and is not surrounded by other tissues. When the polyp is attached to the posterior or posterolateral wall of the lower half of the rectum, and well below the peritoneal reflection, one can fulgurate with very little risk of perforation. Above this level the risk increases.

Although hemorrahge is unlikely during the performance of fulguration it is definitely to be feared. It is encountered most frequently when one tries to fulgurate the pedicle rather than attacking the main polyp. One should remember that there is usually a large artery in the pedicle of the polyp. Hemorrhage may occur several days after separation of the charred area of the polyp in the larger lesions. At the Lexington Clinic this possibility is explained to all patients before they leave the office. They are told that if hemorrhage occurs they should immediately return to our hospital or go to bed and stay in bed until the nearest physician can see them.

FULGURATION: Fulguration should be undertaken only with definite precautions on all large polyps which require periodic and extended treatment. Scarring with partial obstruction of the lumen of the rectum should be considered in the large growths as well as hemorrhage. Some writers even have reported cases of perirectal fistula or rectovaginal fistula after fulguration. The proximity of other organs to the rectum should always be kept in mind when fulgurating any polyp.

"Coaptation" ulcers may occur. These ulcers originate either from transmission of heat generated within the polyp to an adjacent mucosal surface, with which the polyp was in contact or from conduction of the fulgurating current through the carbonized tissue to the immediate adjacent mucosal surface. These small coaptation ulcers are not to be feared. They usually heal spontaneously in several days.

We advise patients to return for additional examinations after all fulgurations. The patients are advised to return in two weeks, three months, six months and one year from the time of the completion of the fulguration. The patient is also told to ask for a thorough proctoscopy and x-ray study of his colon as a part of his annual physical examination. By periodic examinations many complications and malignancies are avoided.

Results

A study was made of one hundred consecutive cases which were handled only by fulguration in order to determine the success of a simple procedure which may be used by the general practitioner in his office. In seventy-two cases the polyp which was fulgurated was found in the rectum and in twenty-eight cases in the lower sigmoid. In the follow-up on this series no recurrences were found after fulguration. Ninety-three patients had a negative barium enema with an air-contrast study. Three patients refused to have the x-ray study made. In that part of the colon which was not seen on proctosigmoidoscopy, x-ray studies revealed polyps in two cases and malignancies in two others. Each of the above also had a benign polyp in the rectum. This shows the value of a routine x-ray of the colon with an air-contrast study for all patients in whom a polyp is found on proctosigmoidoscopic examination. In seven cases more than one polyp was seen at the time of the first proctosigmoidoscopic examination. In twenty-two cases repeat proctosigmoidoscopy revealed a polyp in a location distinctly different from the area where the first polyp had been fulgurated. This tendency to develop a new polyp at a later date shows the need of following these cases from year to year. There were no patients with heredofamilial polyposis in this series.

Conclusions

Very small sessile or pedunculated benign adenomatous polyps may be destroyed by fulguration without undue danger or complications.

Larger pedunculated and sessile benign adenomatous polyps can be safely fulgurated if they are below the peritoneal reflection or

on the posterior wall of the rectum.

Large sessile adenomatous polyps should be subjected to more radical treatment and numerous biopsies should be made.

Pedunculated adenomatous polyps of a larger size may be fulgurated if they are noninvasive and easily reached.

A routine proctosigmoidoscopy should be a part of all general physical examinations because of the frequent finding of adenomatous polyps.

All patients in whom a polyp has been found should have a complete and thorough examination of the colon and rectum including barium enema with air contrast studies.

Repeat examination each year including x-rays of the colon and proctosigmoidoscopy is mandatory once a polyp has been found in the rectum or lower sigmoid.

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Tissue Transplantation—A Review*

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Introduction

PHYSICIANS and their patients have for centuries been fascinated by the prospect of "spare parts"—tissues or organs readily available for replacement use, either directly from human donors or indirectly via "banks". The need for such replacement occurs often at present; when a successful technique is developed, transplantation will be helpful, indeed almost essential, in a vastly enlarged field of disease states. At present, investigation into the various aspects of the homograft rejection mechanism is producing new and interesting information at such a rapid rate that a brief review of progress to date may be of help, especially to those of us not constantly in touch with the problem at the research level.

The early history of tissue transplantation is of course obscure—it is difficult to believe that post-traumatic cross-implantation of extremities and other organs was not at some pre-historic stage attempted—but one of the best-documented early experiments was carried out by John Hunter in 1793. He obtained successful "takes" using cocks' combs and spurs[1], and questionable results with human teeth[2]. Another classic study was Alexis Carrel's in 1908[3], in which he outlined the surgical technique, and the short term successful results obtained, in transplantation of blood vessels, kidneys, extremities, and even an entire head—all, need I say, in experimental animals. Medawar, in 1944,[4] with his description of the "second-set" phenomenon, demonstrated the "individual tissue specificity" of the rejection mechanism, and investigation since then has been increasingly aimed at making clearer the basic characteristics of the homograft rejection response.

Definition of Terms

Homostatic graft—a graft which is used structurally by the recipient, but which does not itself survive.

Homovital graft—a graft whose tissue survives as a functioning part of the recipient.

Implant—tissue grafted by placing it on or in viable recipient tissue.

Transplant—tissue grafted by establishing, surgically, vascular connections between graft and recipient.

Autograft—a graft of tissue from one portion of an individual to another portion of the same individual.

Isograft—a graft of tissue from one individual to another very closely related individual (i.e., in an inbred strain).

Homograft—a graft of tissue from one individual to another within the same species (e.g., man to man).

Heterograft—a graft of tissue from one individual to another individual of another species (e.g., dog to man).

Among the milestones in tissue transplantation were the first successful corneal graft by Zirn in 1905,[5] and the use of a preserved vascular homograft by Gross in 1948[6]—both these are examples of homostatic grafts, and have been used extensively since. Skin autografts, of course, have long been used, especially in burn

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repair. Successful long-term homovital grafts, however, are so rare as to be almost non-existent. Why? Perhaps we need to know more about the homograft rejection response, if we are to control it.

Characteristics of the Homograft Response

A. The Homograft Response Appears to be an Antigen-Antibody Response Because it Exhibits:

(1) *The "Second - set" Phenomenon* — a skin homograft is normally rejected in 10-14 days; a second skin graft from the same donor is rejected more rapidly. If the second graft is from a different donor, however, it has the normal 10-14 day survival of a "first-set" graft—thus there is an individual tissue specificity in the accelerated "second-set" response.[4]

(2) *A "Recall Flare"*—if, after the rejection of a skin homograft, a second graft from the same donor is applied elsewhere on the recipient, a transient erythema will appear at the site of the previously rejected graft. This is again evidence of the tissue specificity, and is similar to tuberculin reactions in the same circumstances.[7]

(3) *"Adoptive Immunity"* — experimental animal B is rendered hyperimmune to animal A (by tissue graft from A to B). Animal C is then injected with lymph node suspension from B. C becomes immune not only to B but to A as well.[8]

(4) *"Acquired Tolerance"*—in some cases, an experimental animal can be rendered tolerant of homografts from another individual throughout life, if the recipient is injected with a suspension of donor cells shortly before or shortly after birth (the timing varies with different species). This tolerance is thought to occur because the priming graft occurs before the recipient develops immunologic maturity.[9,10]

(5) *Detectable Antibodies* — several authors report detection of antibodies after placement of a homograft — these antibodies are evidently more likely to be intracellular than in the serum.[11, 12, 13]

(6) *No Agammaglobulinemic Response*—antibody production is deficient in agammaglobulinemics. Homovital grafting appears to be successful in those few agammaglobulinemic cases in which it has been attempted.[14]

(7) *Histologic Changes in Nodes*—characteristic and reproducible histologic regional lymph node changes are noted during and after the homograft rejection response.[15]

B. The Homograft Antigen Appears to be Intra-cellular Because:

(1) Donor serum does not produce immunity—transplantation of such cell-less material does not produce a hyper-immune response.[9]

(2) Donor erythrocytes do not produce immunity—transplantation of these cells, lacking nuclei, does not produce a hyper-immune response.[9]

(3) Cross-circulation (but not transfusion) does produce immunity—we must assume here that inadequate dosage or decreased viability of the nucleated cells in a transfusion accounts for the failure of such transfusion to produce a hyperimmune state.[16]

(4) Ultrasonically destroyed donor cells can produce immunity, but not after desoxyribonuclease—this fact identifies the antigen as sub-nuclear in size, and as dependent on a desoxyribonucleic acid complex.[17] (Billingham has recent evidence to indicate this antigen is an aminoacid-polysaccharide complex.)[18]

(5) All tissues of any one individual are antigenically identical—hence the common factor must be cellular or sub-cellular in nature.[19]

(6) A "Histocompatibility Locus" (H-2 usually) has been identified — this adds further evidence to the individual, genetically determined antigen concept.[20]

C. The Recipient Antibody Appears to Arise from Host Lymphatic Tissue Because:

(1) The homograft rejection response is marked by a local influx of lymphocytes at the rejection site.[21]

(2) Regional lymph nodes of the host show characteristic changes (large lymphoid cells) in the homograft response.[15]

(3) Homografts may survive in lymphatic-free areas (e.g. anterior chamber or lens

of the eye).[22, 23]

(4) Donor tissue in a millipore diffusion chamber does not produce immunity—this may be because the chamber prevents exposure of the donor cells to the host lymphatic system.[24]

(5) Blockage of the reticulo-endothelial system decreases the immune response (e.g. as with cortisone[25] or irradiation).[26, 27, 28]

In summary, then The Homograft Response—

(1) Is a state of hypersensitivity induced in the host by an antigen in the donor tissue.

(2) Requires exposure of certain intranuclear particles of the donor cells to the host lymphatic system.

Present Methods of Altering the Homograft Response

Such alterations can be divided into those naturally occurring, and those artificially induced, and again into those alterations involving host factors, graft factors, or host and graft factors.

A. Alteration of Host and Graft Factors
1. Natural Alterations
a. Identical twins (antigenically identical)
(1) skin—first exchanged successfully by Bauer in 1927.[29]
(2) kidney—first exchanged successfully by Murray et al in 1954.[30]
b. Freemartin cattle (these have had intermingling of embryonic circulation, and are mutually tolerant).[31]
c. Family relationship (antigenically similar)—homografts between close relatives, especially mother to child (not father to child) may survive longer than those between non-relatives.[32]
2. Artificially induced alterations—none as yet.

B. Alteration of Host Factors
1. Natural Alterations
a. Agammaglobulinemia (a natural defect in antibody response)—a skin homograft was successfully applied to a patient with this defect in 1955 by Good and Varco.[14]
2. Artificially Induced Alterations
a. Acquired tolerance[33] (see explanation above)—Peer (1957)[32] has made a few attempts in humans in this field—no conclusive data to date. A major hazard is the possibility of "runting" (a process producing lymphoid atrophy and stunted growth, or death, in the host, and thought to be an overwhelming reaction of the graft antibodies against host antigens).[34]
b. Blockage of reticulo-endothelial system
(1) cortisone
(2) total body irradiation (with the necessary corollary: post-radiation marrow transfusions).[28, 35]
(3) Trypan blue, thorium dioxide.[36]
(4) "Immunoparalysis"—with repeated grafts[37] (some investigators are unable to corroborate this).[38]

C. Alteration of Graft Factors
1. Natural Alterations
a. Brephoplastic grafts (use of grafts from very young animals, presumably before the tissue becomes antigenically mature).[39]
2. Artificially Induced Alterations
a. Mechanical alteration of the graft[40] (freezing, bathing in cortisone, radiomimetic drugs, etc.)—this quite often produces a non-viable graft. Billingham has classified this type of procedure as "keeping a cat in a bucket of cold water, hoping it will become a seal!"[18]
b. Use of diffusion chambers (millipore filters)—this prevents the cell to cell contact of donor and host.[41, 42]

Many of the methods listed above are in use in tumor research also;[43] in many respects a malignant tumor appears to simulate a graft which has overcome the characteristic rejection response of its host.[44]

SUMMARY

A. A review and classification of some of the presently known facts concerning tissue transplantation leads to the following conclusions:
1. The homograft rejection response is a state of hypersensitivity induced in the

host by an antigen in the donor tissue.

2. The homograft rejection response requires exposure of certain intra-nuclear particles of the donor cells to the host lymphatic system.

B. Alterations of the characteristic response include those naturally occurring and those artificially induced, with involvement of host factors, graft factors, or host and graft factors. Production of acquired tolerance, and blockage of immune response with irradiation (both methods involving alteration of host factors), appear to be quite promising fields at present.

C. The immense clinical potential inherent in this field is indicated, and the close physiologic and immunologic relationship between tissue transplantation and tumor growth is mentioned.

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The Rehabilitation of Hearing Impaired Children and Adults in Kentucky

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THIS article is designed to offer general information to Kentucky physicians concerning hearing rehabilitation services performed by qualified audiologists in the state of Kentucky. Although many physicians have become acquainted with the services of an audiologist, others have not had occasion to learn about this comparatively new field.

A recent publication[1] listed 152 hearing rehabilitation centers in the United States. One of these was the Audiology Clinic at the University of Kentucky in Lexington. This Clinic was opened in 1954. In June, 1958, a Hearing and Speech Center for the Kentucky Society for Crippled Children was opened in Louisville. A Hearing Conservation Center was opened in Elizabethtown by the State Department of Health to serve 20 adjacent counties. This Center will offer audiological evaluations.

An audiologist was defined recently by a group of authorities as: "One who specializes in the field of hearing, and particularly hearing disorders. He is concerned with the assessment of hearing, and the habilitation and rehabilitation of children and adults with impairment of auditory function. He may teach in a college or university, may be concerned primarily with research, or with clinical activities or direct a university, hospital, community, or governmental hearing center."[4]

There has been a long felt need in Kentucky for trained personnel and facilities for the educational rehabilitation of the hard of hearing. The Audiology Clinic of the University of Kentucky has been established as a training center where students in Clinical Psychology and Special Education interested in specific problems of the hearing handicapped are offered coursework and clinical training. Graduate students are offered staff assistantships which enable them to receive firsthand clinical experience.

At present, there is no full-time training program for audiologists in the Louisville area. However, coursework primarily designed to help teachers and other personnel actively engaged in the rehabilitation of the hearing handicapped will be offered regularly at the University of Louisville.

Services Offered

Both of the previously mentioned Centers offer direct services to children and adults of all ages. These services include the determination of organic hearing acuity, hearing aid evaluations, lip reading, auditory training, speech and language therapy and counseling. Functional hearing loss (non-organic loss) is assessed primarily by certain standardized clinical tests including psychogalvanic skin response audiometry, delayed speech feedback, the Stenger Test, the Lombard Test, and the Doerfler-Stewart Test. Descriptions of the tests can be found in the published literature.

The hearing aid evaluation deserves some clarification. The initial phase consists of a battery of clinical hearing tests for determining threshold acuity and supra-threshold discrimination. These measurements include air conduction, bone conduction and speech reception thresholds, speech discrimination scores, and loudness perception. All these tests contribute toward the first phase of the examination which is to determine whether or not a hearing aid

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is indicated. If it is determined that an amplifying instrument can be used, the next phase of the evaluation deals with comparative measurements between hearing aids consigned to the clinic. The aids are compared by means of free field speech audiometry with and without interfering noise, and puretone audiometry which may include continuous, pulse, or warble tones. Thus each aid is tested for speech discrimination with or without interfering environmental conditions and the ability of the hearing aid to overcome the threshold loss. The examination determines how much of the loss is recovered by each hearing aid. A recommendation is then made for a specific hearing aid. This recommendation is based not only on the described clinical tests but also on the patient's evaluation of the aid as to its intelligibility and comparative freedom from noise. A center doing hearing aid evaluations does not sell hearing aids or accessories but has, for purposes of comparison, an appropriate selection of hearing aids supplied by the various hearing aid companies. The patient is seen for follow-up after he has purchased his hearing aid. He is given training in the care and use of his instrument.

Another function of the audiologist is research. Various problems of the hearing impaired which have been or are being studied in the Centers include the incidence of hearing loss, lip-reading, effects of delayed speech feedback, speech perception in noise, psychogenic hearing loss, auditory malingering and the validity of psychogalvanic skin response audiometry as well as the effectiveness of binaural hearing aids.

Facilities, Referrals and Fees

The facilities of each of the described Centers include two separate, specially designed hearing laboratories, two therapy rooms, observation rooms for visitors, parents or professional personnel, an electronics workshop, a waiting room and office space.

Each patient must be referred by a physician who submits a medical report of the condition of the ears, nose, and throat and any other pertinent information. At the Louisville Hearing and Speech Center the referral is made by or through an otologist. After the evaluation a typewritten report is sent to the referring physician covering the findings and recommendations as a beginning step in the follow-up.

The Centers are non-profit and are dependent upon fees for portions of their operating expenses; however, no one is denied services if he is indigent. Any hearing handicapped person may receive rehabilitative aid regardless of race, creed, color or income.

With the development of these essentially recent services in Kentucky, it is important for audiology and medicine to enter a teamwork approach so as to encompass both the medical and educational rehabilitation of the hearing impaired individual. The first consideration of any hearing loss—mild or severe—is medical (or otological) examination and treatment. The two centers are well equipped to assess the degree of hearing loss for the physician and to teach speech and language to children and adults by means of lip reading (speech reading), speech therapy, auditory training and speech developmental procedures.

The Need for Audiologic Study

Kodman, Acuff and Stockdell[3] completed a study of the incidence of hearing loss in Kentucky school children for the State Department of Health. They estimated that between 40,000 and 50,000 of our public school children have some degree of hearing loss that deserves medical and/or educational consideration. This year, 1959, forty counties are conducting hearing surveys assisted by the Bureau of Maternal and Child Health. As the cases are detected, the need for adequate follow-up becomes increasingly important. Hearing studies throughout the United States show that school children with impaired hearing exist in large numbers, although the exact figure is debatable. Our data concerning the number of hearing impaired infants and pre-school children is very meager. They do in fact exist and need immediate attention, often in the form of a differential diagnosis to rule out other factors such as mental retardation, aphasia, emotional disturbance and psychic deafness.

The services offered by the Centers for children are many and varied. The audiological assessment is applicable to infants and children of pre-school and school age. It is no longer necessary to wait for the child to "outgrow" his hearing loss or to wait until he is 8-9 years

old before he is tested. Many youngsters can wear hearing aids as early as age two. It is generally agreed that human learning is most rapid from age three to six. Any youngster who is delayed in speech and language due to a hearing loss or aphasia should receive special training *before* he enters school and not after he has failed the first two or three grades.

Medical and audiological consideration of the hearing impaired adult has been urgently recommended by Jordan[2] and Shambaugh and Carhart.[5] They suggest audiologic study for the patient being considered for such surgery as fenestration, stapes mobilization, or for Meniere's disease. The audiologist can be helpful when psychogenic deafness or auditory malingering is suspected. Three other types of cases are worthy of mention—the infant being considered for adoption, candidate for tonsillectomy or adenoidectomy and medico-legal cases involving compensation for hearing loss or deafness.

Since World War II, many technological advances have been made in audiological measurements. Tuning fork tests and puretone audiometry have been augmented by objective P.G.S.R. audiometry, improvements in bone conduction measurements, the developments of speech reception tests and a battery of tests for measuring loudness recruitment. Recent developments include tests of auditory fatigue, tonal decay, aural overload and objective speech audiometry (P.G.S.R. using speech stimuli). In the evaluation of the malingerer and the psychogenic, increased use is being made of the Lombard test, the Doerfler-Stewart test, the shifting voice technique, hypnotherapy, psychological tests and delayed speech feedback.

Summary

The authors have discussed some of the recent advances in a relatively new field. They have pointed up some of the advantages and applications for medicine in general and otology specifically. Early diagnosis and treatment of the hearing impaired will yield a more favorable prognosis. The audiologist is willing to assume a portion of the responsibility for the welfare of the hearing impaired patient.

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The Clinical Use Of Antithyroid Drugs*

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SINCE their introduction by Astwood in 1943, the antithyroid drugs have maintained a definite, though limited, place in the treatment of hyperthyroidism. Administration of these drugs is consistently followed by a complete remission of all clinical and laboratory evidence of thyroid overactivity.[1] In fact, doses that are large enough and given long enough are capable of producing myxedema in either normal subjects or those with hyperthyroidism.

Mode of Action

The antithyroid drugs act by blocking the formation of thyroxin, apparently by preventing the synthesis of iodide to di-iodotyrosine. Following their administration there is therefore a gradual reduction in the protein-bound-iodine content of the blood and of the thyroid gland.[2] Thyroxin that is already circulating is unaffected. Hence, there is a latent period of from four to eight weeks before maximum effect is achieved.

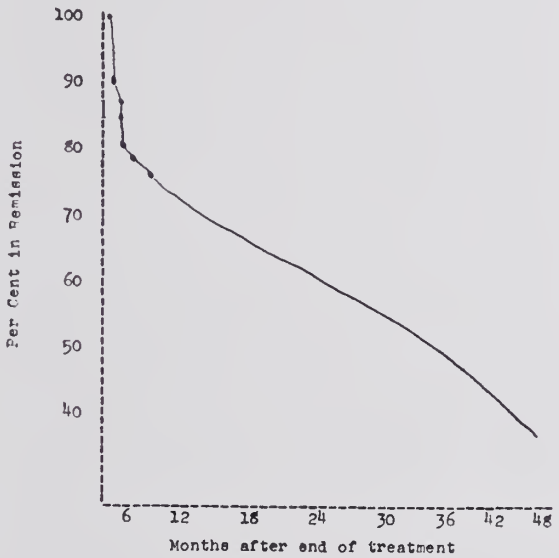
Deterrents to Clinical Use

The latent period is not a serious deterrent to clinical use. The major disadvantages are that the induced remissions are frequently of short duration unless antithyroid medication is given permanently and that toxic effects are not rare.

Duration of Remission. Solomon[3] administered antithyroid drugs to 101 patients and then studied the patients again four years after cessation of treatment. Twenty-four had a relapse within three months after completion of therapy. Twenty-one others had a recurrence at a later time. Fifty-six remained well for at least four years after one course of treatment.

A second course of treatment was undertaken in 33 of the 45 patients in whom hyperthyroidism recurred. Twelve remained well. Of the remaining 21 patients, 12 received a third course and of these, three obtained permanent remissions. In other words, remissions of up to four years' duration were secured in 71 of the original 101 patients.[3] These results are summarized in table I. These studies indicate failure of drug therapy in 30% of the patients. Such a failure rate is too high and certainly much higher than that reported for either thyroidectomy or radioactive iodine.

TABLE I



Percentage of Remissions in 101 Patients Treated by Propylthiouracil Alone (Solomon)

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Toxic Reactions. Toxic reactions to antithyroid drugs have been reported in from .7% to 9.6%[4] of patients. The list of toxic manifestations is long and is summarized in table II.

TABLE II

Toxic Effects of Antithyroid Drugs

Psychosis	Urticaria
Chilliness	Rash
Fever	Pruritus
Hyperhidrosis	Alopecia
	Purpura
Lymphadenopathy	Aching joints
Increased exophthalmos	Anorexia
Headache	Nausea and vomiting
Malaise	Diarrhea
Jaundice	Leukopenia
Polydipsia	Agranulocytosis
Dryness of mouth	Thrombocytopenia
Hematuria	Anemia

*Presented at the third annual Fall Clinical Conference of the Lexington Clinic on October 22-23, 1958.

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Propylthiouracil is apparently the safest of the antithyroid drugs. It has caused reactions in only 1.6% of treated patients,[2] and there were no deaths in a series of 2,491 cases.[5] A further safety factor is the finding that 70% of untoward reactions occurred during the first eight weeks of therapy.[4]

Agranulocytosis is of course the major problem. It can be successfully treated if it is promptly recognized. Hence, at the beginning of antithyroid therapy, each patient must be told that the symptoms of agranulocytosis are fever, chills, and sore throat. He must be warned to stop his medication and report at once to his physician should these (or any other untoward symptoms) appear. A white blood count must be done immediately. If agranulocytosis is found, prompt antibiotic and supportive therapy should be begun and continued until the blood count returns to normal and the patient is clinically well.

Skin rashes and drug fever are minor problems with propylthiouracil. Withdrawal of the medication will be followed by disappearance of the fever and rash. Frequently the patient can, after a week or two, gradually resume therapy without further difficulties. However, should symptoms or drug sensitivity then reappear, one of the other antithyroid drugs can often be used successfully.

At the Lexington Clinic we have found that, under proper supervision, propylthiouracil is a relatively safe drug. We have had no serious untoward reactions in our 12-year experience with its use.

Indications for Use of Propylthiouracil

In our opinion, propylthiouracil is indicated, (1) as a routine preoperative medication for all except the very mild toxic goiter, (2) for hyperthyroidism during pregnancy or puberty, (3) for the rare patient with a severely toxic nodular goiter and another serious disease, and (4) for certain cases of postoperative recurrence of hyperthyroidism.

Preoperatively. The use of propylthiouracil preoperatively has made the surgeon's task an easier one. Two-stage operations are no longer necessary. "Thyroid storms" never occur. The patient can usually arrive for surgery in a calm, well-nourished, euthyroid state. Ample time is provided to overcome cardiac decompensation and arrhythmias.

Our method has been to begin administration of propylthiouracil in doses of 150 mg. every six hours and to give Lugol's solution, five drops three times a day; this regimen is continued until all clinical and laboratory evidence of hyperthyroidism has disappeared. We then discontinue the use of propylthiouracil one week before operation to avoid the possible coincidence of a toxic reaction to the drug and the time of operation. However, therapy with Lugol's solution is continued.

The following case illustrates this method:

A 38-year-old white housewife presented herself with a six-month history of nervousness, palpitation, increased appetite, increased sweating, intolerance to heat, and a weight loss of 42 pounds. She had evident and severe thyrotoxicosis, with a firm, diffuse goiter, marked tremor, and a basal metabolic rate of plus 84%. Therapy with propylthiouracil and Lugol's solution was begun, and within seven weeks she had regained her weight and strength. Clinical and laboratory evidence of thyrotoxicosis had disappeared. Propylthiouracil therapy was discontinued at the end of the seventh week, but use of Lugol's solution was continued. One week later a subtotal thyroidectomy was performed. She made an uncomplicated recovery and has remained well for eight years.

During Pregnancy. Pregnant women who develop thyrotoxicosis can be successfully treated with propylthiouracil alone. After delivery, thyroidectomy can be performed. Little or no effect on the fetus has been observed, although occasionally the baby has a temporary enlargement of the thyroid gland.[6] The following case illustrates the use of propylthiouracil during pregnancy.

A 26-year-old para I, gravida II white female began to have signs and symptoms of thyrotoxicosis during the second month of pregnancy. She had become increasingly nervous and overactive and had lost 11 pounds in spite of an increased food intake. The resting pulse rate was 120 per minute and the basal metabolic rate was plus 47%. Propylthiouracil therapy was begun in doses of 600 mg. daily and continued for six weeks. At the end of this time all symptoms and signs of thyrotoxicosis had abated. The dosage of propylthiouracil was then gradually reduced to 50 mg. three times a day and was continued until at term

she was delivered of a 7½ pound normal male infant. The child had no thyroid gland enlargement. Propylthiouracil therapy was continued in the same maintenance dose of 150 mg. daily for six weeks after delivery. A subtotal thyroidectomy was then performed. She made a good recovery and was in excellent health when last seen, five years after her thyroidectomy.

During Puberty. Our experience has been that thyrotoxicosis occurring during puberty is a self-limited disease. Hence, the patient can be safely tided over the acute phase of the disease with antithyroid medication, and surgery can thus be avoided. An example follows:

A 15-year-old girl had a diffuse goiter with thyrotoxicosis of five months' duration. The basal metabolic rate was plus 36%. She was treated with propylthiouracil in the usual manner. The initial dose was 600 mg. daily. After six weeks she had become euthyroid and the dosage was gradually reduced to 50 mg. twice daily, which was continued for 14 months. The medication was then stopped, and when last seen 3½ years later the patient was in good health and free of any signs or symptoms of thyrotoxicosis.

When Another Serious Disease Prevents Thyroidectomy. We have found the antithyroid drugs to be useful when thyroidectomy for one reason or another cannot be performed. The following case illustrates such a situation:

A 47-year-old housewife had severe thyrotoxicosis due to a large multinodular goiter and in addition had a carcinoma of the anus, which had been bleeding profusely. She entered St. Joseph Hospital and received four transfusions of whole blood. She was started on therapy with Lugol's solution and propylthiouracil. At the end of two weeks the hemoglobin content of the blood had returned to normal, but the thyrotoxicosis was still so severe as to make us hesitate to perform surgery of any kind. Hence, we continued the use of propylthiouracil for four more weeks. At this time she had become euthyroid. The anal carcinoma was removed by means of a combined abdominal-perineal resection. Postoperatively she was maintained on 150 mg. of propylthiouracil a day, and thyroidectomy was performed 16 weeks after the abdominal-perineal resection. The use of propylthiouracil was discontinued for one week prior to thyroidectomy, and Lugol's solution given. She then remained in good health for nine more years but now has developed metastases from the original carcinoma.

With Postoperative Recurrence of Hyperthyroidism. An example of the postoperative use of propylthiouracil is seen in the following case.

A 42-year-old single white female had had a thyroidectomy for Graves' disease in 1925 and subsequently had had two subsequent operations for recurrence of goiter with thyrotoxicosis. When first seen here in 1948 she had again developed thyrotoxicosis, but further operation was refused by the surgeon and radioactive iodine therapy was refused by the patient. She was therefore started on therapy with 600 mg. of propylthiouracil daily, and within six weeks she became euthyroid. She has remained euthyroid for ten years with doses of 200 mg. daily.

Summary and Conclusions

The antithyroid drugs, particularly propylthiouracil, have a useful place in the treatment of hyperthyroidism. Because of a high relapse rate, therapy with this drug alone cannot be considered a definitive treatment of hyperthyroidism, except in puberty. With propylthiouracil, toxic reactions are not a serious problem.

We at the Lexington Clinic believe that antithyroid drugs are indicated as a routine preoperative medication for toxic goiters in certain cases of postoperative recurrence of hyperthyroidism, and in pregnancy and puberty. Occasionally they should be used to control thyrotoxicosis so that more severe associated pathology can be dealt with successfully.

Careful instruction of the patient and close supervision by the physician are essential for early detection and prompt treatment of toxic reactions.

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Hiatus Hernia*

J. B. Holloway, M.D.** *Lexington, Ky.*

DURING the past five years one-hundred and sixty-five patients with the diagnosis of hiatus hernia have been seen at the Lexington Clinic. Only twenty-five of these patients were operated upon, indicating the conservative approach that we adopt toward this disease.

Most cases of hiatus hernia are asymptomatic. Others, however, cause periodic mild discomfort, severe epigastric distress, burning, eructation, angina-like pain, intestinal obstruction or shock due to bleeding. Confirmation of the diagnosis is made by x-ray or gastroscopy. Since, in most cases, there are no symptoms the hernia is usually found incidentally at fluoroscopy on a gastrointestinal study. In this series the patients age varied from twenty to eighty-six years.

Indications for Surgery

At the Lexington Clinic, surgical treatment is undertaken only when other diseases such as coronary arteriosclerosis, chronic cholecystitis and duodenal ulcer have been ruled out and when the patient has symptoms which are not responding to medical treatment. The medical regime consists of weight reduction where indicated, a bland diet, antacids and elevation of the head of the bed. The presence or absence of symptoms does not seem to be related to the size of the hernia. Some of the most distressing symptoms have resulted from very small herniae, whereas some of the largest herniae with as much as two-thirds of the stomach in the thoracic cavity were absolutely asymptomatic.

Surgery should not be undertaken unless one is certain that hiatus hernia is causing the trouble; preliminary studies therefore should include cholecystography and electrocardiography. While the surgical approach may be either transthoracic or transabdominal, the former was used in the majority of these patients because of the comparative ease of repair. However, approach was made from below when concomitant abdominal pathology was present but the symptoms have indicated that the hiatus hernia was also causing considerable trouble. When using the abdominal approach one may correct additional pathology or confirm the absence of it.

Results

There has been no mortality in this series and complications have been few. There was one case of atelectasis and one case of wound infection which cleared satisfactorily. The results have been uniformly splendid, with complete cessation of symptoms and with no recurrence of the hernia as determined by postoperative x-ray examination. This is one operation in which the patients seem to be uniformly quite enthusiastic about the result. This is a paramount indication for continuing the careful selection of cases. It is certainly not an indication for extension of surgery to a larger group which would include doubtful cases and would probably result in a proportion of dissatisfied patients. The mere existence of a hiatus hernia is no indication for operation. Performing surgery to repair a hiatus hernia before making a thorough investigation of the cardiac and complete gastrointestinal status of the patient is asking for trouble.

If the operative approach is through the chest the incision is usually made at the level of the seventh rib. After the esophagus is mobilized the diaphragm is usually opened. The sac is pulled down and then sutured to the undersurface of the diaphragm after the method of Allison. The diaphragmatic crura are approximated snugly behind the esophagus. Several small sutures are made between the esophagus

Presented at the third annual Fall Clinical Conference of the Lexington Clinic, October 22 and 23, 1958.

**Division of Surgery, Lexington Clinic.*

and the diaphragm itself. The phrenic nerve is not crushed. If the repair is accomplished from below, approximation of the diaphragmatic crura may be quite difficult. Simply reducing the sac and attaching it securely to the under side of the diaphragm in several places may be satisfactory. In this series of cases we have not encountered the so-called short esophagus. This should not create a problem, however, for the esophagus may be mobilized and brought anteriorly through the dome of the diaphragm at its highest point.

Conclusions

Surgical treatment of the diaphragmatic hernia is entirely satisfactory and operation may be successfully carried out with the approach from either above or below. Operation should be limited, however, to those patients who do not respond to medical management and who are proven not to have a concomitant cardiac or gastrointestinal ailment.

Meet Us In Louisville

September 22-24

for

KSMA'S Annual Meeting

Louisville General Hospital

A Case of Rheumatoid Arthritis with Neurovascular Manifestations

Presented by Xuan Truong, M.D., Resident in Physical Medicine and Rehabilitation

History

A forty-eight-year-old farmer developed increasing pain, swelling and stiffness, first in the fingers, and successively in the wrists, shoulders, neck, back, toes, ankles, knees, and hips in 1955. A year later he developed frequent tingling in the hands and feet, bilateral foot drop, and had lost 40 pounds. He was first seen by a physician at this time, and started on Prednisone. In January 1958, he developed ulcerations on both lower legs, and the joint symptoms became worse, reducing him to a bed and a wheel chair life.

Findings

A thorough medical evaluation was done in June 1958. The patient was found to be emaciated and unable to stand unaided, to have several large ulcerations around the left ankle, bilateral peroneal paralysis with foot drop, severe generalized muscular atrophy, fusiform swelling and hyperextension deformities of the fingers with ulnar deviation. The knee joints were enlarged. There was no active inflammatory arthropathy. There were rheumatoid nodules around the elbows. Arterial pulsations in the feet were good. There was an accelerated sedimentation rate, a leukocytosis, and a positive latex fixation at 1/320 dilution. Serum albumin was 3.25 gms% and globulin 3.43 gms%. L. E. preparation was negative. Gastrochnemius muscle biopsy showed thrombosis of small arterioles and non-specific focal atrophy and fatty infiltration of the muscles. X-ray films of the lumbar spine showed diffuse demineralization. ECG was normal except for occasional premature ventricular contractions. EMG showed fibrillation potentials of 20 to 30 microvolts in various sites of the left tibialis anticus, consistent with a peripheral neuropathy with denervation. Muscle strength evaluation showed generalized weakness ranging from 25 to 40%, except in the instrinsic muscles of the hands and in the gastrocnemii and solei where weakness was about 75%, and in the peronei, tibiales, and intrinsic muscles of the feet where weakness rated 100%.

Treatment

The patient was hospitalized in June 1958 and established on gradually reduced doses of Dexamethasone and Aspirin. He was also given Norethandrolone, vitamins, Premarin, and a high protein diet. The leg ulcers were treated conservatively with topical measures. Limited physical therapy included underwater exercises and mecholyl iontophoresis. More extensive physical measures were later included in his program of total rehabilitation.

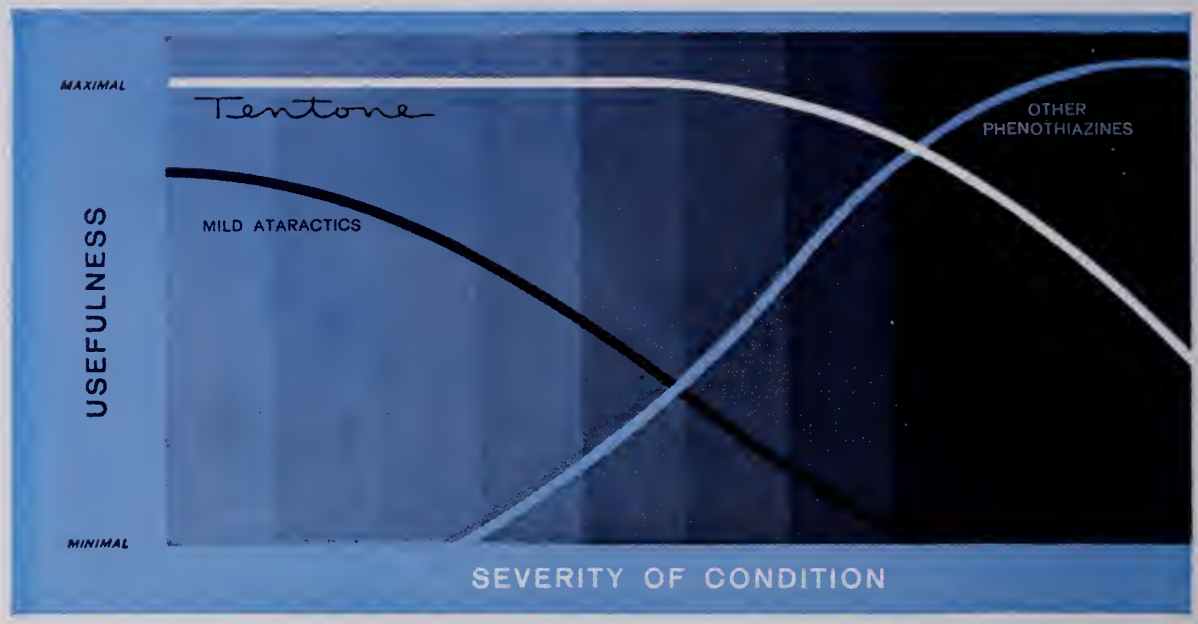
Total rehabilitation was started when the patient was admitted to the Department of Physical Medicine and Rehabilitation in August 1958. This included continued medical control, intensive daily physical therapy in the forms of Hubbard Tank with underwater active assistive exercises to the extremities, strengthening exercises to the upper extremities, hips and knees, electrical stimulation and re-educative exercises to the ankles and feet, and

(Continued on page 582)

ANNOUNCING



A HIGHLY EFFECTIVE TRANQUILIZER FOR EXTENDED OFFICE PRACTICE USE



POSITIVE CALMING ACTION ADAPTED FOR LOWER RANGE OF EMOTIONAL DISORDERS

The development of TENTONE® Methoxypromazine Maleate *Lederle* does not duplicate primary function of existing tranquilizers. TENTONE fills the need for a practical, potent agent for extended use in everyday practice (as illustrated above).

Action of TENTONE Methoxypromazine Maleate approaches that of the strong phenothiazines without their drawbacks. Calming response is positive and rapidly apparent to both patient and physician. However, as a basic phenothiazine modification, TENTONE allows full therapeutic application in the mild and moderate range of anxiety-tension and somapsychic disorders most usually seen in general practice.

EXCELLENT TOLERATION— MARKED REDUCTION IN COMPLICATIONS

Incidence of untoward reactions is exceptionally low and approximates the mild ataractic drugs. Reduction in sensitivity reaction, intestinal distress, blood, brain or liver toxicity is striking, particularly in the low dosage range. TENTONE exhibits greater freedom from depression and drug habituation. Physical and psychic orientation is usually preserved. Occasional drowsiness may be encountered, particularly in higher dosages. In moderate to more severe cases, this sedative effect may be desired.

TENTONE has thus been described as one of the easiest tranquilizers to handle in office practice. In indicated cases, the physician may be relieved of the patient's unnecessary concern over his own illness. In contrast to the previous types of drugs, complaints over induced distress or inadequate benefit are rare.

WHEN MORE THAN MILD SEDATIVE EFFECT IS DESIRED

Consequently, TENTONE is more useful than other ataractic drugs in two areas: (1) mild to moderate conditions—when more than mild sedative effect is sought, (2) middle range of moderate to severe cases—when less than psychopathology is involved.

Indications include ■ common anxiety-tension states ■ obsessive-compulsive behavior ■ neurosis ■ depression ■ situational anxiety and hysteria

And the emotional components of: ■ agitation ■ restlessness ■ tremors ■ insomnia ■ alcohol- and drug-withdrawal syndrome ■ hyperkinesis ■ prenatal anxiety ■ rheumatic disorders ■ dermatoses ■ menopausal syndrome ■ premenstrual tension ■ peptic ulcer, other g.i. disorders ■ asthma, other allergy ■ multiple sclerosis, arteriosclerosis ■ malignancy, other progressive diseases

POSSIBLE POTENTIATION OF ANALGESICS AND NARCOTICS

Since tranquilizing drugs may potentiate the action of pain-relievers, sedatives, and barbiturates, they should be used with caution in conjunction with them, or to achieve a greater response to these drugs in various conditions when desired. They may also be useful in reduction of effective dosage to better tolerated, or non-habituating levels.

ADAPTABLE LOWER DOSAGE RANGES

Dosage must be individualized to severity of condition and response desired.

In mild to moderate cases: varies from 30 to 100 mg. daily.

In moderate to severe cases: from 75 to 500 mg. daily.

In psychotic or institutionalized patients, TENTONE may be useful as a substitute when toxicity precludes effective dosage of other phenothiazines, or as maintenance after hospitalization. Dosage may range from 100 to 1500 mg. daily in divided doses.

Supplied: 10 mg., 25 mg. and 50 mg. tablets



Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

gait training with bilateral short-leg braces; occupational therapy consisting of mobilizing and strengthening activities for the extremities; training in activities of daily living, recreational therapy, vocational and social counseling.

Course

The patent's medical condition showed gradual improvement as evidenced by subsidence of his joint symptoms, healing of the leg ulcers, and some return in muscular function. He developed several complications including pressure lesions in the back, and severe allergic reactions to the Nitrofurazone ointment used on his leg ulcers. These complications were slowly brought under control.

The patient responded well to the rehabilitation program, gained strength in most muscles, and although the severely involved musculature of the lower legs showed little functional return, he was able to ambulate with his braces and tend to his self-care activities quite satisfactorily. His medical condition concurrently improved with his physical activation, and he showed a weight-gain of sixteen pounds. He was discharged in November 1958, to continue physical therapy on an out-patient basis and at home. It was felt that the patient offered at this time a definite vocational possibility and he was referred to the State Bureau of Rehabilitation Services for Vocational follow-up. Following his discharge, the patient presented certain vocational problems that will be pointed out in the following discussion.

Discussion

Rex O. McMorris, M.D.,
Chairman—Department of Physical Medicine and Rehabilitation

This patient was presented for several reasons. First, to demonstrate the recently emphasized occurrence of peripheral neuropathy associated with rheumatoid arthritis. Second, the value of a coordinated medical and physical medical approach to this disabling disease. Third, to point up some of the problems facing a rehabilitation program that is directed toward replacing the patient in society as a useful citizen.

The peripheral neuropathy can be a profound sensory and/or motor paralysis with or without ischemic skin lesions producing slowly healing ulcers or frank gangrene. This patient demonstrated all of these features. We have had two other cases, one with peripheral sensory involvement alone and one with both sensory and motor loss, both associated with rheumatoid arthritis. In both cases of motor loss, those muscles with complete paralysis gained very little reinnervation after prolonged therapy. Muscle biopsies in these cases have been reported elsewhere as showing an arteritis.[1] As noted, biopsy on this case also showed thrombosis of small arterioles and evidence of denervation as focal atrophy. The underlying pathology is considered an extensive connective tissue disease with an arteritis, subsequent perineural arteriolar thrombosis and ischemic neural degeneration. This pathological process needs more controlled investigation.

Since rheumatoid arthritis involves multiple connective tissue systems, one must keep in mind that ligaments, tendons and joint capsules can become contracted and muscles can be atrophic. No matter if the medical management controls the inflammatory processes, one must use physical medical procedures to maintain joint range and muscle strength. If the patient cannot use the body parts for functional purposes after controlling the disease there is little point in treatment. Retraining the arthritic in self-care and activities of daily living is usually one of the first steps in physical restoration. Besides reconditioning the program involves strengthening of certain muscle groups for functional purposes, the application of splints, braces or assistive aids and training the patient to use them.

Those that have the potential for going back into their old job, or trainability for a new vocation, need special attention in a total rehabilitation program. This patient had a unique vocational situation and points up some problems of management. He had farm machinery and was renting a farm when he became ill. Although he completed his rehabilitation with definite physical limitations he was an intelligent man, and it was thought that with the help of his two single sons, he could manage the farm very satisfactorily. Unfortunately one son was drafted, the other left home, he sold his farm equipment, applied for Old Age and Survivors' Insurance on the basis of disability, and retired. In this particular instance, this procedure is not too tragic because of the constant threat of flare-ups with arthropathy especially if he gets out of medical control. It does, however, relegate him to a sedentary existence which is conducive to recrudescence of his disease. He ceases to be a productive

(Continued on page 615)

EDITORIALS

"More Roads To Recovery"

THE medical profession will have the opportunity to cooperate with the American Hospital Association in the observance of National Hospital Week, May 10-16.

It is to our mutual advantage to work together toward overcoming any erroneous impression, by some, that hospital costs are greater than the service the patient receives. An explanation of the better care of the patient, improved techniques and skill, and an understanding of the problems of the hospital will go far to offset this criticism.

Medical progress in recent years has created a new world of health. Since 1910, twenty years have been added to the average life span. Good medical care and its indispensable component, good hospital care, have become true necessities for living.

Increasingly, the roads to recovery are centered in the hospital. In 1957 there were nearly 23 million admissions to the nation's hospitals. This means there was one admission to a short-term hospital for every eight people in the United States. In 1935 less than 37% of all births occurred in hospitals and in that year the maternal death ratc was 58 for every 10,000 births. By 1956 over 95% of births were in hospitals, and the death rate was down to 4 per 10,000 births.

In 1946 there were 4400 short term hospitals and only 53% had electrocardiograms. By 1957 there were 5300 hospitals and 92% had this tool essential in the appraisal of the condition of the heart. In 1937 the first hospital blood bank was established and by 1957 there were 3200 of the 5300 short term hospitals providing this service. Radioactive isotopes were found in 300 hospitals by 1952. In 1957 there were 900 hospitals who had radioactive isotope departments. Recovery rooms which provide intensive care in the critical period following surgery have been established in nearly 2000 hospitals compared with only 500 in 1951. The numbers of hospitals with premature nurseries rose from 1600 in 1953 to 2500 in only four years.



You might expect that the increase in complexity of care and the more numerous services would mean that the average patient would spend more time in the hospital. On the contrary, the more effective care and more efficient procedures have reduced the average hospital stay to 7.6 days.

The public is now spending 5.3% of the consumer's dollar for medical care, including hospital service, as compared with 3.7% in 1929. This investment is resulting in better health and postponement of death.

In 1957 for each of the 21 million admissions to the short term hospitals there was an average of about $26 cost for each day of care, or a little over a dollar an hour. Part of the increase in costs is the result of inflation, but the real increase is the result of expanding services. Since payrolls now account for 61% of the expenditures of the short term hospitals compared with 53% in 1946 every 10% rise in payrolls will mean a 6% rise in total costs.

Each physician will have a personal interest and responsibility to help win public support for the hospital or hospitals in which he practices. Let's all do our share for "More Roads to Recovery."

George W. Pedigo, Jr., M.D.

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

A Time for Action

INTEREST in providing legislation to adequately meet the medical care needs of the indigent was high in the 1958 State Legislature and indications are that more bills on this vital subject will be introduced in the next session. Last year's experience would indicate that steps aimed at resolving this problem will undoubtedly be made.

With the firm belief that the public has the right to expect physicians to take the initiative when the provision of medical care is the issue, the House of Delegates of the KSMA has authorized the drafting of legislation to help solve this problem for introduction in the 1960 State Legislature.

It has requested that all members of the profession express an active interest in the passage of this KSMA measure. Since we believe that it is inevitable that some bill purporting to solve this problem will be passed—it is incumbent upon us to be certain that the best possible legislation to render such medical care is enacted. We are obligated to our patients and to our profession to take action on this issue—now.

Gaithel Simpson, M.D.
Chairman, Committee on Medical
Education and Economics

Journal To Get A "New Face"

The Journal will present a "new face" to its readers starting with the June issue when a newly designed cover is scheduled to be used for the first time. After three years, the familiar gold colored cover is being replaced by a blue one—symbolic of the Blue Grass State. Decision to recommend the change was made at a meeting of the Advisory Committee to the Editor and Departmental Editors in March. The new cover was chosen from artist's drawings by the editors and approved by the Council of the KSMA. Comments on the new cover will be welcomed.



Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

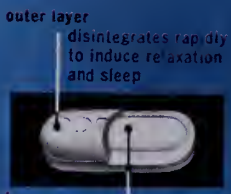
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*Brown, S. S.; Libo, H. W., and Nussboum, A. H.: Norethondrolone in the Successful Monagement of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Acodemy of Pediatrics, Chicago, Oct. 20-23, 1958.

For those patients who complain

carries your patients through the middle of the night





Each Nebralin timed-release tablet contains:

Dorsital* ..... 90 mg.
Warning: May be habit forming

Mephenesin ....425 mg.
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Dosage: One or two tablets ½ hour before retiring.

about waking up at 2 A.M.



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NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2, 3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

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SPECIAL ARTICLES

The End Of The Beginning*

ROBERT W. ROBERTSON, M.D.

Paducah, Ky.

THIS is the end of the beginning for you. In about ten weeks you may say, in the words of the apostle Paul: "I have fought a good fight. I have finished my course. I have kept the faith. Henceforth there is laid up for me a crown of righteousness." For your twenty years of faithful and diligent study and self denial and the great sacrifice of your devoted parents, you will not at present receive a crown of righteousness, but soon a coveted medical degree.

Your Education

You are most fortunate to have been born in the United States of Amercia, for in this country you have the opportunity to attend the finest colleges and medical schools. Students who are accepted for medical schools today are more carefully selected, better educated, and are better adjusted than in the past. Although I had an A. B. Degree when I entered medical school thirty-two years ago, many studied medicine after only two years of a pre-medical course. Fifteen or twenty years prior to that you could enter medical school out of high school. This gradual raising of standards in your education, as a whole makes you more imbued with the humanities and conversant with the world problems than ever before. You are more critical of what you are told; think for yourselves. You are not content with spoon-feeding, and less tolerant of mediocrity.

Only in Great Britian and Scandinavia will you find medical schools on the level with the one you attended. I recently heard an internationally known surgeon and teacher discuss the medical schools he visited in Europe, South America, and Asia. Many of these schools were government-controlled, with very large classes. He stated there was not enough bedside instruction and that the lecture system dominated the curriculum. He felt the system prevented the growth of the inquiring mind and intellectual curiosity of many of these students. He did feel that there were some brilliant minds among these young men who, if given opportunity, would make fine doctors.

As a member of the licensure board of Kentucky, we have frequent requests from foreign graduates wanting a license to practice in this state. All of our states are having the same problem and during the last ten years applications have been received in the United States from over eighty different countries. Some of these men have had excellent training in our approved hospitals. We are losing some of the more select and suitable of these foreign graduates to our own tubercular and mental institutions, and occasionally there is an opening in your medical school, or, in this hospital where one could be used. We feel our license law is too strict at times, as this high-type of foreign doctor is not content with a limited license which has to be renewed each year. I feel our board is generally agreed that some type of modification of our law would help solve the situation. To assist in the solution of this difficult problem, the Educational Council For Foreign Medical Graduates was recently formed by representative groups in this country. I understand your dean, Dr. Kinsman, is chairman of this committee, which has already held two very rigid examinations for these selected foreign graduates, whose schools have not been approved by the American Medical Association. Thirty-six states have consented to accept

**Address of the KSMA President at Senior Day in Louisville, March 16, 1959.*

for license men who pass this examination although their school is not approved. As stated above, we still cannot accept these men unless our law is modified.

I do not want to give the impression that our license board wants to let the bar down so that it is easy for foreign graduates to get into this state to practice, but we do feel we are losing some of the best to our institutions.

Difficulty in getting a license should never be your lot, and it is gratifying to see our highly standardized medical schools are all for the best and promise a better type of physician for the nation. You have been trained in the newer methods of studying the basic processes of disease by observation rather than by didactic lecturing, and in your last two years you have studied the recognition and diagnosis of the common and serious lesions as well as the indications for the right therapy in the wards of this hospital. The type of training you have received stimulates a desire in you to continue your education after graduation. It is not the amount of knowledge, but how to use it that counts. The philosopher, A. N. Whitehead, aptly said: "Education is the acquisition of the art of the utilization of knowledge."

It is now generally agreed that a doctor's education is not complete without the study of the entire individual as well as his disease, patient-centered not merely disease-centered. Another is patient-physician relation. Another is physician-physician relation, and finally physician-student relation. During these last two years you have experienced all of these relationships.

Your Postgraduate Training

When I finished medical school, there seemed to be a scarcity of approved internships, and there were certainly not enough approved residencies for all who desired further specialty training. In this state, only this hospital (General Hospital, Louisville) was approved, and it was about the same all over the United States, with about the only approved postgraduate training available in a hospital connected with a medical school. There was not an approved residency in surgery in the big city of New York until Allen Whipple, M.D., initiated the program at the Presbyterian Hospital there in the early 1920's. As this hospital was early in having an approved training program, applications were received from graduates from medical schools all over the United States, and any doctor who was accepted for an internship or residency considered himself most fortunate.

Today the situation has changed. So many men were seeking further education and specialty training following World War II that our hospitals had to greatly expand their facilities for this service. The residency expansion was out of proportion to the internships. Today, there are approximately 14,000 approved internships, and 30,000 approved residencies. It is impossible to fill all these positions even with the estimated 10,000 foreign graduates either serving internships or taking residency training in this country.

So the big problem today is not the difficulty for you Seniors in securing hospital appointments, but in the hospitals filling all the available places with good men and women graduates.

Each of you is an individual—different from all other individuals because you are a product of your ancestry, your environment and your training. Together with your experience and your personal reactions to them, you possess certain characteristics and a personality peculiarly your own. Your training and education are patterned to fashion you into a well-adjusted, useful member of society, and of your profession. Although you have had the same pattern of training, your capabilities are different. Some of you are better suited in different fields of medicine and research, and as water seeks its level, you too will find your proper place.

Let me stress here the importance of your not rushing into private practice without hospital training. It will give you experience and confidence that years of practice cannot match. Too often I have heard doctors say that if they had it to do over again they would have taken more hospital training.

Our Changing Medical World

We live in a changing world—full of scientific changes and changes in education and practice. I might mention a few of the changes that have taken place in this country in the past twenty years that have had a profound influence on disease and injury. They are: the discovery of penicillin and the other antibiotics; the development of the Salk vaccine which if continued to be used extensively can probably completely eradicate poliomyelitis; the control of T.B. by specific chemotherapy; the develop-

ment of the Blood Bank with the ever-ready preserved blood available, enabling many lives to be saved; the development of the heart-lung apparatus that has finally enabled surgeons to do open heart surgery and to cure abnormalities that could never be attacked before; the vast improvements in all types of physiotherapy, making life brighter for many hopeless cripples; the wider and more specific attacks on cancer with the hope in the not to distant future of a cure. These are just a few of the scientific changes that have taken place in my medical generation. You, in the future, will see even more and greater changes if our system of complete freedom for research and practice is allowed to continue to exist.

Problems You Must Face

Perhaps your curriculum did include problems confronting medicine today. If not, let me stress the importance of your being well-versed in these problems. I feel that every medical school should present some such course before graduation. For instance, before us today is the dispute between organized medicine and the United Mine Workers Health and Welfare Fund. This problem is best stated in the Principles of Medical Ethics of the American Medical Association, December 1954, Chapter 7, Section 4, Free Choice of Physician:

"Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not per se cause a contract to be unethical. A third party has a valid interest when, by law or volition, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability."

In the new Principles of Ethics adopted by the House of Delegates for the AMA in June 1957, this section does not appear. Instead, attention is directed to Sections 6 and 7, particularly the former:

"A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."

The third party problem is a problem frequently encountered between organized medicine, on the one hand, and on the other, industry, labor unions, insurance groups, and hospitals with full-time radiologists and anesthesiologists.

Group Health Insurance For 65 Plus—U.S.A., in the form of the Forand Bill is an impending issue in Congress. If this bill is passed, it will mean federal medical care for all Social Security recipients of 65 years of age and over, and dependents. If enacted into law, this would add *Thirteen Million* persons to Social Security Rolls. This would establish the principle that provision of medical care for the entire population is a federal function. Complete nationalization of medicine might be inevitable. You, as doctors, must always remember that the objective of the medical profession in this country is and always has been to serve the health needs of the people. This can be best done by a society of free practitioners who must be ever conscious of their social obligations to the public. An excellent example of how the health of our nation has flourished under a free system was previously shown by the many foreign doctors coming to this country for training and seeking permanent residence. Make as one of your chief aims in life to keep free the finest system of medical care the world has ever known.

As you may know, one duty of a member of the State Board of Health is to hear and investigate any complaints about a physician who is not abiding by the law. My experience in serving twelve years on this board has been very illuminating and at times saddening. Too often I have seen a promising young doctor arraigned because of indiscriminate issuance and use of narcotics. There can be many pitfalls and besetting sins that can so easily undermine the stones of a stalwart character so that his house will crumble in wreckage. You have gone through all of this preparation in order to render a great service. Do not let anything mar your victory.

Maybe your chief problem when you start out in practice will be how long it will take to pay off your debts. But things could be worse. Statistics show that in the gay nineties the chances were three to one that a doctor starting in practice could not make a living. In 1891 a Doctor W. R. Hurbert polled 100 of his medical friends about five years after he graduated.

He found no less than seventy-one of them earning money in ways other than the practice of medicine.

Twenty-three received salaries for assorted non-medical jobs.

Fifteen others were proprietors of drug stores.

Four were money lenders.

Three were working for medical journals.

Three were insurance agents.

Two were farmers.

One each made his living from real estate, drug selling, preaching, book selling, patent medicine manufacturing.

One never tried to practice.

One sawed wood for a living.

Twelve reported they had given up practice in disgust.

Another problem you will face is the increasing demands on your time as your practice grows. You will have trouble spending enough time with your families, getting enough of much-needed rest, getting away for postgraduate courses. For example: The average American is making twice as many visits to physicians as he did twenty-five or thirty years ago. The American population is being hospitalized at three times the rate of 1940. Moreover, disability rates are higher, with heavy concentration of prolonged illness in the older age groups. Herbert R. Mayes, in the 75th Anniversary of the Journal of the American Medical Association observes: "Doctors have given the people a greater life-span, more time for themselves. What do the people, the consumers of medicine, want now? They want more of the doctors' time. Their chief complaint is that doctors are too busy; we are no sooner ushered into their office than we are ushered out. We would like to talk more, to tell them more; we would like them to explain more, to listen more."

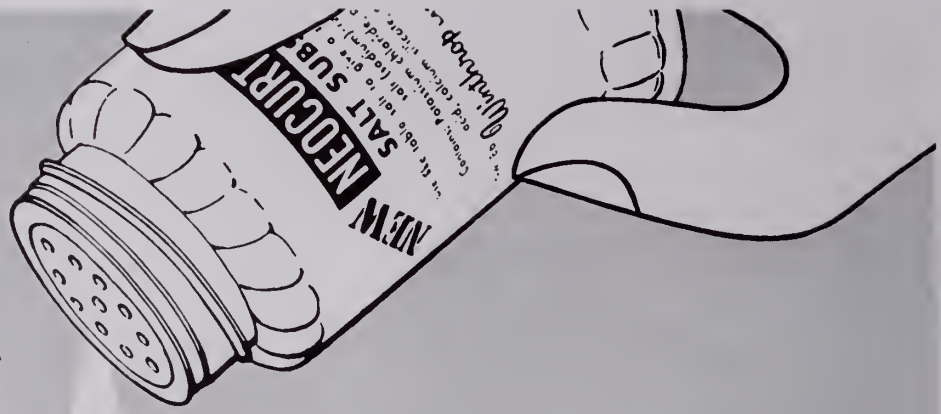
You will be confronted with many difficult and sad situations in the sick room. You will find some patients and families hard to satisfy, and at times you will feel like giving up in despair. On the other hand, most of your work will be pleasant. Most of your patients will get well, and you will be happy in seeing them recover.

I can imagine as the twenty years of going to school crept by you felt it was an endless eternity; and now you wonder how quickly they have passed. As this is the *end of the beginning* you think of the friends, mistakes and opportunities you have made, and I am sure you are wondering what the future will be like. Your profession is not crowded. There is not a town in Kentucky, or I dare say in the United States, of any size that would not welcome you. There are always vacancies in salaried positions, in industry, in state and local health departments, mental institutions, federal civilian health services, and medical schools have reported unfilled positions for physicians every year for the past decade. The Army and Navy are always ready to offer a career to a doctor.

Your Life and Your Future

Along with this medical degree goes a certain responsibility. You have a service to humanity to render. This opportunity for service is as great as any profession known. This is a privilege that you have earned, and that should be honored, revered and never abused. Let me at this point refer you to the Kentucky State Medical Journal, July, 1957, page 635; "The new Principles of Medical Ethics." They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public. A good physician or surgeon demands a good man. He should be endowed with cheerfulness, courage, kindness, and patience. Always be courteous. Abraham Lincoln was riding in a carriage of state with several of his cabinet one day, and passed an old darkey who was an ex-slave. When the old colored man took his hat off and bowed to Mr. Lincoln, he responded by taking off his hat and also bowed. One of the cabinet members inquired as to why the President of the United States would take off his hat to an ex-slave, and Mr. Lincoln's response, was "I do not want anyone to show more courtesy to me than I do to them."

There is an art in practicing medicine, and the more you develop this art the more successful and happy you will be in your work. If you will work, study, and keep the Hippocratic Oath, material blessings will unfailingly accrue. But let me plead with you not to have as your life goal just material gain. Large possessions bring worry, envy on the part of others, and are apt to crush that which is finest in man. In the end, character alone remains as the bulwark of all that is worthwhile in life.



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ORGANIZATION SECTION

Guest Speakers for Annual Meeting Announced by Dr. Robertson

The name of the speaker at the President's Luncheon of the 1959 KSMA Annual Meeting has been announced by Robert W. Robertson, M.D., Paducah, chairman of the KSMA Committee on Scientific Assembly and Arrangements.



Dr. Berry

Frank Brown Berry, M.D., Assistant Secretary of Defense (Health and Medical) will be featured as President's Luncheon speaker and will talk on some of the highlights of his work in that office. Doctor Berry graduated from Harvard University Medical College in 1917. He was appointed to his present office in 1954.

He practiced surgery in New York State from 1924 until 1954, and was formerly professor of clinical surgery at Columbia University and director of the First Surgical and Chest Division of Bellevue Hospital. Doctor Berry is a Diplomate and founder-member of both the American Board of Surgery and the Board of Thoracic Surgery.

Guest speaker representing the Kentucky Dental Association during the general session will be Henry M. Wilbur, D.D.S., professor of dentistry and director of graduate and postgraduate education of the University of Louisville School of Dentistry. His subject will be "Pedodontics Grows Up: The Science of Dentistry for Children." He is head of the Department of Pedodontics at the dental school and in 1955 was elected president of the Executive Council of the American Society of Dentistry for Children. He is a charter member and past president of the American Academy of Pedodontics. Doctor Wilbur is a graduate of the University of Michigan, School of Dentistry.



Dr. Wilbur

Dists. 12 and 15 Meet May 14 at Cumberland Falls

The Twelfth and Fifteenth KSMA Councilor Districts have scheduled a joint meeting at duPont Lodge, Cumberland Falls, Corbin, on Thursday, May 14, according to an announcement from District Councilors Garnett J. Sweeney, M.D., Liberty, and Keith P. Smith, M.D., Corbin.

Robert W. Robertson, M.D., Paducah, KSMA president will speak following dinner. His subject will be, "There Ought to be a Law." The afternoon session will feature scientific presentations by three Louisville M. D.'s.

Following are the speakers and their subjects: Sam A. Overstreet, M.D., "Chronic Cholecystitis"; John S. Harter, M.D., "Lesions of the Esophagus"; and Oscar J. Hayes, M.D., "Fibroids and Pregnancy."

AMA Meeting Features Added Interest for Kentuckians

The Report of the Commission on Medical Care Plans and Related Subjects which will be included in the meeting of the AMA House of Delegates at the annual convention of the American Medical Association in Atlantic City, New Jersey, on June 8-12, should provide more than the usual degree of interest in the meeting on the part of Kentuckians.

Among other things the KSMA's answer to the two questions posed by the AMA will be presented by Kentucky's two delegates W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville. Kentucky's answers to the questions may be found in the report of the special meeting of the KSMA House of Delegates on page 596.

Hypnosis, staphylococcal infections, blood cell disorders, space medicine, European spas, and a special session on new concepts in the aging are some of the subjects to be considered at the AMA's annual meeting.

Some 450 physicians will present scientific papers or participate in panel discussions and symposiums during the meeting. In addition, there will be 387 scientific exhibits shown by physicians and 285 industrial exhibits prepared by pharmaceutical houses, and other business organizations. Most of the scientific sessions will be and exhibits will be held in the Atlantic City Convention Hall, but some scientific meetings will be held in hotels.

All physicians are invited to attend the one-day session on the aging on June 10, which is being held under the auspices of the AMA Committee on Aging. This session which will include a series of panels is designed to present the practicing physician with a

concentrated review of current thinking regarding health care of the aged.

Immediately prior to the opening of the annual AMA Association Convention, the seventh annual National Civil Defense Conference will be held on June 6 in Atlantic City. It will feature the medical problems involved in nuclear warfare. This conference will be opened by Louis M. Orr, M.D., Orlando, Fla., who will be inducted as AMA president at the AMA meeting. Chairman of the AMA Committee on Disaster Medical Care is Harold C. Lueth, M.D., Evanston, Ill.

Dr. Robertson to Speak May 28 at Meeting of Dists. 1 and 3

"What Government Gives—Government Can Also Take Away" will be the title of a talk by Robert W. Robertson, M.D., KSMA president, at the joint meeting of the First and Third Councilor Districts at Kentucky Dam Village on May 28.

Doctor Robertson will talk following the dinner, according to J. Vernon Pace, M.D., Paducah, and Ralph D. Lynn, M.D., Elkton, councilors for the 1st and 3rd Districts, respectively.

Scientific presentations by three Louisville physicians will be given during the afternoon. Marion Beard, M.D., will speak on "Vitamin B-12 in Diagnosis and Treatment"; George Sanders, M.D., on "Thyroid Cancer"; and Kenneth Crawford, M.D., on "The Golden Scourge."

Attendance Record Set by KDA at 99th Annual Session

A record attendance of 1,875 was recorded at the 99th annual meeting of the Kentucky Dental Association in Louisville on April 5-8, according to A. B. Coxwell, D. D. S., Louisville, secretary-treasurer of the Association.

Woodford B. Troutman, M.D., Louisville, KSMA secretary, was guest speaker on the program representing the Association. His topic was "Heart Disease in Relation to Your Profession." Representing the KSMA at the annual dinner of the KDA was Robert W. Robertson, M.D., Paducah, KSMA president. Russell Teague, M.D., State Commissioner of Health, spoke at the opening sessions of the meeting. Six dental authorities were featured on the program.

For the first time in the history of the KDA, the son of a former association president was elected to fill the same office. Julian M. Dismukes, Jr., D.D.S., Paducah, was elected to take the presidency next year. His father Julian M. Dismukes, Sr., was president in 1948.

Lyman E. Wagers, D.D.S., was installed as president to succeed Frank W. Jordan, D.D.S.; Doctor Dismukes is president-elect; Vincent Barr, D.D.S., Frankfort, is first vice president; J. M. Stokes, D.D.S., Mayfield, second vice president; Jack Salisbury, D.D.S., third vice president. Delegates to the ADA, V. A. Tagliarino, D.D.S., Louisville; and Russell I. Todd, D.D.S., Richmond. The association resolved to work for the election of Doctor Todd as president-elect of the ADA either in 1960 or 1961.



State winner in the American Association of Physicians and Surgeons essay contest Carole Siebert (right) is shown receiving a KSMA check for $100 from George H. Riley, M.D., a member of the Campbell-Kenton Medical Society's essay contest committee. Carole was the top winner in Campbell-Kenton County and then went on to win the state-wide contest sponsored by the KSMA. Her essay will now compete for the AAPS national prize of $1000. Essays were judged on the state level by a committee selected by KSMA'S Committee on Public Information and Service.

Four M.D.'s on Program of Meet at Mammoth Cave Hotel

Speakers at the scientific section of the Fourth and Sixth Councilor Districts at Mammoth Cave Hotel on June 18 will cover the subjects of cardiovascular diseases, duodenal ulcers, and the RH factor.

Those presenting the scientific section of the meeting and their subjects are: Robert Tillett, M.D., Louisville, "Anticoagulants in Cardiovascular Disease," Glenn Bryant, M.D., Louisville, "The RH Factor," and Leslie C. Dodson, M.D., Owensboro, "Duodenal Ulcer."

KSMA president Robert W. Robertson, M.D., Paducah, will give a talk on "What Government Gives—It Can Also Take Away" following the dinner meeting. Announcement of the meeting was made by W. Keith Crume, M.D., Bardstown, Fourth District; and John P. Glenn, M.D., Sixth District.

Dr. Witten Elected Vice Speaker

Carroll L. Witten, M.D., Louisville, was elected vice speaker of the American Academy of General Practice's Congress of Delegates at the meeting during the 11th annual scientific assembly of the AAGP in San Francisco on April 4-9.

Total registration of the four-day meeting was 6,095—with 2,730 physicians registered. Representing Kentucky at the meeting were: Charles G. Bryant, M.D., Louisville, KAGP president; Daryl P. Harvey, M.D., Glasgow, KAGP president-elect; Doctor Witten and Frank L. Duncan, M.D., Monticello, delegates to the Congress; John E. Ryan, M.D., Louisville; Francis Halcomb, Jr., M.D., Scottsville; William F. O'Donnell, M.D., Hazard; and Louise Caudill, M.D., Morehead.

Seventh District Schedules Meet on June 25 in Frankfort

The annual meeting of the Seventh Councilor District will be held at the Frankfort Country Club in Frankfort on Thursday, June 25, according to Wyatt Norvell, M.D., New Castle, councilor for the Seventh District.

It is scheduled to begin at 4 p.m. (CDST) with the scientific portion of the program being held first.

Following is the meeting program:

4:10 Scientific presentation, E. S. Weaver, M.D., Carrollton

4:30 Scientific presentation, Livingston A. Wahle, M.D., Shelbyville

4:50 Discussion

5:00 "Third Party Medicine," G. N. Combs, M.D., Pikeville

5:20 "Legal Problems and Decisions Confronting the Medical Profession," E. Gaines Davis, Frankfort, KSMA legal counsel

5:35 Open Discussion of Third Party Medicine
KSMA president, legal counsel, and councilors present
Business Session
Social Hour

7:00 Dinner
Address, Robert W. Robertson, M.D., Paducah, KSMA president

KPHA Annual Meeting in Louisville Attended by 800

Gaithel Simpson, M.D., Greenville, chairman of the KSMA's Committee on Medical Education and Economics, was one of the featured speakers at the Kentucky Public Health Association's 11th annual meeting in Louisville on March 31-April 1-2. Doctor Simpson spoke on the problems of indigent-medical care in Kentucky.

Carl Cooper, M.D., Bedford, who serves as a consultant in the Trimble County Health Department, was honored as the citizen contributing the most to public health in Kentucky. The Bowling Green Civitan Club was honored as the group contributing the most to public health.

New officers of the KPHA elected at the meeting included Miss Ruth Spurrier, director of public health nursing for the State, who was named president-elect, succeeding M. A. Shepherd, M.D., Henderson County health officer who took office as president. Other new officers are: Thomas P. Summers, Jeffersontown, executive director of the Kentucky Tuberculosis Association, vice president; Marjorie K. Smith, M.D., medical director of the Kentucky Crippled Children's Commission; and B. F. Brown, M.D., Daviess County health officer, directors.

Among the speakers featured at the sessions was Berwyn Mattison, M.D., executive director of the American Public Health Association. About 800 attended the three-day sessions.



Blue Shield was the topic of discussion when Donald Stubbs, M.D., Washington, D. C., chairman of the Board of Blue Shield Medical Care Plans, got together with Lane Tynes, Louisville, executive director of Kentucky Physicians Mutual; and Branham Baughman, M.D., Frankfort, member of the National Blue Shield Commission.

Kentuckians Attend Conference of Blue Shield Plans

The annual Conference of Blue Shield Plans at Bal Harbor, Fla., on April 13-16 was attended by 11 members of the Board of Directors of Kentucky Physicians Mutual—the Blue Shield plan for Kentucky.

J. Vernon Pace, M.D., Paducah, president of the Board, led the Kentucky delegation. Other physician members attending were: Branham B. Baughman, M.D., Frankfort, member of the National Blue Shield Commission; J. C. Bell, M.D., Louisville; William H. Cartmell, M.D., Maysville; Delmas M. Clardy, M.D., Hopkinsville; John Dickinson, M.D., Glasgow; Ralph D. Lynn, M.D., Elkton; Richard J. Rust, M.D., Newport; and Garnett Sweeney, M.D., Liberty. Lay board members attending were S. A. Ruskjer, Louisville, and J. P. Sanford, secretary.

Stanley T. Simmons, M.D., Louisville, medical consultant, D. Lane Tynes, Louisville, executive director and Don Giffen, Louisville, assistant executive director, also attended the meetings.

A number of Kentuckians who are board members of the Ky. Blue Cross attended a similar conference of Blue Cross Plans which was held at the same time.

Radium Society Elects Dr. Love

Jesshill Love, M.D., Louisville, was recently elected president-elect of the American Radium Society. His election highlighted the 41st annual meeting of the Society at Hot Springs, Va., in April. He will assume the presidency in 1960.

The American Radium Society is composed of radiologists, surgeons, and other physicians who specialize in the use of radiation in treatment. Theodore R. Miller, M.D., New York City, is the new president of the Society. Next year's meeting will be held in San Juan, Puerto Rico on March 17-19.

KSMA Committee Meetings

Committee on Public Information and Service

N. L. Bosworth, M.D., Chairman

Lexington **March 12**

The Committee expressed appreciation to the Jefferson County Medical Society and the University of Louisville School of Medicine for their participation in the Senior Day Program March 16.

It recommended to the KSMA Council that a luncheon and program welcoming new members be included in the annual meeting program. A recommendation was also made that the council implement a positive program for "teams" of eastern Kentucky physicians to speak to county medical societies and councilor district meetings on the ills of third party medicine by urging these groups to make their meetings available for this purpose and by assuming some of the financial expenses of these "teams."

To help create enthusiasm among committees and to build good public relations, it was recommended that a news release be given to the press after committee meetings when appropriate.

Associate Committee on Public Health

Delmas Clardy, M.D., Chairman

Louisville **March 19**

Plans were made for the sixth annual "Immunization Week" which the committee sponsors each year.

Compulsory vaccination for diphtheria, pertussis, tetanus, and polio was recommended to the KSMA Council, in compliance with a request from the KSMA Advisory Committee on School Health.

The committee felt that the KSMA should publicly endorse the use of influenza vaccine, fluoridation of water, and a safety program to reduce accidents. It also voted to promote an education program to let the public know the relationship of smoking to lung cancer, and the simplicity and inexpensiveness of the smear test to detect cancer of the cervix.

Executive Committee of the Rural Kentucky Medical Scholarship Fund Board of Trustees

C. C. Howard, M.D., chairman

Louisville **April 2**

Action was taken on several items and advanced consideration was given to others that will be presented when the full Board of Trustees meet on May 21.

Counties in most critical need of physicians were discussed and the committee will recommend to the Board of Trustees that Owsley County replace Cumberland County as one of the 10 counties most in need of physicians.

The scholarship program was reviewed. It was pointed out that 166 students have received loans since the program started in 1946. Seventy-nine of this number are in medical school or taking internship training. Forty-eight are now practicing in rural areas. Others are serving their time in the armed forces. while many others have fulfilled both their moral and financial obligation before moving.

A study was made of funds available for new loans in 1959-60. The committee will advise that approximately 18 new loans be made.

Associate Committee on Diabetes

Robert J. Hoffmann, M.D., chairman

Louisville **April 16**

The committee was highly pleased with the results of the 1958 Diabetes Detection and Education Drive. Records indicate that 90,430 free urine sugar tests were run and 175 newly proved diabetics discovered.

The previous high number of tests was in 1957 when 52,400 free urine sugar tests were done with 137 newly proved diabetics reported.

KSMA's news clipping service sent 314 clippings on the 1958 drive to the Headquarters Office, demonstrating that the KSMA is receiving broad publicity on this public service effort.

According to the American Diabetes Association, Kentucky has one of the outstanding diabetes detection programs. Since the 1958 drive was so highly successful the committee made very few changes in the procedure to be followed in the 1959 campaign.



Listening intently to what Clyde Sparks, M.D., Speaker, left, is saying at the Special House of Delegates meeting in Lexington on March 26 are—left to right—George W. Pedigo, Jr., M.D., vice speaker; Robert W. Robertson, M.D., Paducah, KSMA president; Irvin Abell, Jr., M.D., president-elect; Garnett J. Sweeney, M.D., chairman of the Council; and Carlisle Morse, M.D., vice chairman of the Council.

Digest of Proceedings

Special Meeting of the KSMA House of Delegates

Fireside Room, Phoenix Hotel Thursday, March 26, 1959

Clyde C. Sparks, M.D., Speaker, Ashland, Presiding

The special meeting of the House of Delegates of the Kentucky State Medical Association was called to order at 3:10 p.m. by the Speaker of the House, Clyde C. Sparks, M.D., Ashland.

The Speaker then obtained permission of the House to appoint a Credentials Committee. Following a brief intermission the Credentials Committee reported that there was a quorum. Doctor Sparks then stated that this was a special meeting of the House called for the purpose of giving the AMA the answers it requested on the following two questions:

1. *Free Choice of Physician*—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable and essential to good medical care without qualification?

2. *Closed Panel System*—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

At 3:21 p.m. the House voted to go into executive session.

Since it is not customary to report discussion of the members of the House while in executive session, it is sufficient to state that there was a full and adequate discussion, as demonstrated by the fact the the microphone was approached 45 times by 36 members. A recording of the proceedings of the executive session is on file in the Headquarters Office.

At the conclusion of the special session at 5:45 the House voted to give the following answers to the AMA questions:

1. FREE CHOICE OF PHYSICIAN—Acknowledging the importance of free choice of physician, is this concept to be considered a fundamental principle, incontrovertible, unalterable and essential to good medical care without qualification?

(Answer)

We affirm the principle of "Freedom of Choice" of physician provided that the physician—

(a) is competent to render services as defined by the highest standards within the framework of Organized Medicine

(b) avoids economic exploitation of the patient

(c) in every other way adheres to the Principles of Medical Ethics.

(d) "Free Choice" is meaningless unless the county societies throughout this country vigorously, and without fear or favor, maintain the best medical standards in accordance with Section 4 of the Principles of Medical Ethics which states:

"The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession."

2. CLOSED PANEL SYSTEM—What is or will be your attitude regarding physician participation in those systems of medical care which restrict free choice of physician?

(Answer)

"We are unequivocally opposed to physician participation in closed panel systems which exert economic or administrative pressure in influencing the patient's right to participate. Any system, plan, panel, etc., which does not guarantee the freedom of choice of physician as provided for in the answer to the first question is to be condemned and not recognized: and any physician participating in such a plan, system, panel, etc., other than those established by law, is open to censure by the local, state, and national medical societies."

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Discussing plans for the panel discussion at a breakfast which preceded the County Society Officers Conference are—left to right—Donald Cass, M.D., Hollywood, Calif.; Ernest B. Howard, M.D., Chicago; Karl Nygren, Chicago; Hugh Brenneman, Lansing, Mich., and Robert W. Robertson, M.D., Paducah.

Hosp. Assoc. Installs Officers at Annual Session

Malcolm H. Black, of the TB Hospital in Glasgow, is the new president-elect of the Kentucky Hospital Association. He will succeed Wade Mountz, of the Norton Infirmary, Louisville, in 1960, who was installed as president at the Association's annual meeting in Lexington in April.

Other officers named at the meeting are: Mrs. Elizabeth Simmerman, Lexington and Cincinnati, executive secretary, and E. W. Horgen, Ashland, treasurer.

Thomas O. Meredith, M.D., Harrodsburg, Eastern vice president of the KSMA, represented President Robert W. Robertson, M.D., Paducah at the annual dinner of the Association. A highlight of the dinner was the presentation of twenty-five year certificates of recognition by Madison R. Brown, M.D., associate director of the American Hospital Association, to 14 hospitals.

Hospitals receiving the certificates were:

Berea College Hospital—Berea
William Booth Memorial Hospital—Covington
T. J. Samson Community Hospital—Glasgow
James B. Haggin Memorial Hospital—Harrodsburg
Jennie Stuart Memorial Hospital—Hopkinsville
Good Samaritan Hospital—Lexington
St. Joseph Hospital—Lexington
Children's Hospital—Louisville
Jewish Hospital—Louisville
Kentucky Baptist Hospital—Louisville
Kosair Crippled Children's Hospital—Louisville
Norton Memorial Infirmary—Louisville
Red Cross Hospital—Louisville
St. Joseph Infirmary—Louisville

Co. Soc. Off. Program in March Attended by 151

One-hundred and fifty-one of Kentucky's medical leaders heard nationally-known authorities discuss the problems of "third party medicine" at the County Society Officers Conference in Lexington on March 26.

Despite bad weather, attendance was above that recorded in 1958 when 137 attended. Highlighting this year's meet was a panel discussion on the developing problems in third party medicine. Included in the panel were: Hugh Brenneman, M.D., Lansing, Mich., moderator; Ernest B. Howard, M.D., Chicago, Ill., Karl Nygren, Chicago, Ill. and Donald Cass, M.D., Hollywood, Calif.

Light spot in the meeting was an illustrated talk by Russell Roth, M.D., Erie, Pa., entitled, "What's So Funny About Practicing Medicine?" Donald Stubbs, M.D., Washington, D. C., talked on Blue Shield and its relationship to American medicine.

A special meeting of the KSMA House of Delegates followed the meeting. Digest of the meeting may be found on page 596 in this Journal.

County Auxiliaries Fete M.D.'s in Doctor's Day Activities

Physicians from throughout the state have been honored by the women's auxiliaries of the various county societies with Doctor's Day activities.

Doctor's Day—the day set aside to honor physicians—is usually celebrated on or around March 30 in commemoration of the use of ether as an anesthetic agent in a surgical operation by Crawford W. Long, M.D., Georgia.

Members of the Henderson and Pulaski County Medical Societies celebrated the day on March 30. Each doctor was honored with the traditional red carnation, the official Doctor's Day flower. Carnations were given out at the Henderson County Auxiliary in the coffee shop of Methodist hospital, Henderson, where coffee and doughnuts were served to physicians. In Pulaski County, a covered dish dinner was served to members of the county society.

In Jefferson County, the Mayor of Louisville, proclaimed April 13 as "Doctor's Day" and the annual Doctor's Day dinner dance was held at the Kentucky Hotel on April 25. This is the first year such a proc-

lamation has been made.

Hopkins County Doctors were presented with red carnations for their lapels by members of their women's auxiliary who celebrated the day on March 26.

U of L Med. School Alumni Seek to Raise Quarter-Million

The goal of the University of Louisville Medical School alumni in U of L's development program is to raise $2,489,585 this year. Each of the 1,250 physicians in Kentucky who attended the medical school will be contacted personally and others will be contacted by mail, according to R. Glen Spurling, M.D., Louisville, chairman of the campaign's medical-alumni committee.

Twenty-four physicians—including 10 co-chairmen from Jefferson County—have been named to direct the drive in 15 districts of the state. District physician chairmen include: George Brockman, III, Greenville; Samuel Flowers, Middlesboro; Rex E. Hayes, Glasgow; Robert Jasper, Somerset; Maurice Kaufmann, Lexington; Joseph Liebman, M.D., Frankfort; Charles F. Long, Elizabethtown; Hugh Mahaffey, Richmond; W. Vinson Pierce, Covington; R. W. Robertson, Paducah; William Mountjoy Savage, Maysville; Clyde C. Sparks, Ashland; F. Hayes Threlkel, Owensboro; Earl Wright, Pikeville.

Jefferson County co-chairmen are: Charles G. Bryant, David M. Cox, Charles Edelen, K. Armand Fischer, D. P. Hall, Hampden C. Lawson, Sam A. Overstreet, George W. Pedigo, Jr., and Rudolph F. Vogt, Karl D. Winter.

Four Groups Make Up Board of Hospital Commission

Four organizations now make up the Board of the Joint Commission on Accreditation of Hospitals, Kenneth B. Babcock, M.D., Commission Director, reported in a recent bulletin issued by the Commission.

Representation on the Commission includes: American College of Physicians, 3 votes; American College of Surgeons, 3 votes; American Hospital Association, 7 votes; and the American Medical Association, 7 votes. The new representation was voted by the members of the Corporation following the resignation of the Canadian Medical Association on January 1. The Canadian group resigned to give full support to the newly formed Canadian Council on Hospital Accreditation.

In September, 1958, the KSMA House of Delegates passed a resolution presented by the Jefferson County Medical Society that the KSMA support the American Academy of General Practice in its efforts to gain membership on the Joint Commission.

According to the latest Bulletin there are 3,896 hospitals accredited by the JCAH, and the proportion of accredited and not accredited remains fairly constant. In 1958, 89.6 per cent of the surveys done resulted in accreditation and 10.4 per cent resulted in no accreditation. During 1958, the Commission reported that an average survey cost $175.

STUDENT AMA

So Many, So Kind . . .

Inasmuch as this will be the last SAMA column that this reporter will be privileged to write, I should like to devote it to the recognition of some people who have made my job easier and the medical student's life more full.

First, to the KSMA goes our sincerest appreciation for their interest in the student and his organization. The recent Senior Day program was excellent—Doctor N. Lewis Bosworth and his committee did a fine job. The continuing financial support given to SAMA by the KSMA makes it possible to send several interested students to the annual SAMA national convention, thus providing us with well equipped men to run our local chapter. The very existence of this column is, to us, an indication of the spirit of acceptance which we have enjoyed as students from this vigorous state society.

Along this line, a special word of thanks to Mr. Joe Sanford, who, in spite of his multitudinous duties, is never too busy to listen to our problems and aid us in times of need. His many considerations in our behalf will not soon be forgotten.

Thanks, also, to our Dean, Doctor Murray Kinsman for his gracious cooperation in our projects and his help in reorganizing SAMA last year into an effective organization.

To Doctor Sam Overstreet a word of gratitude for his kind editorial comments about SAMA.

Our appreciation also extends to the Jefferson County Medical Society and to their fine Executive Secretary, Mr. Harry Lehman. We are most grateful for their part in the Senior Day and for their wholehearted support of the fledgling Physician-Student Advisor Program. The society and particularly Dr. Lucas's committee have done all within their power to make this a successful program.

And now my personal thanks to all those mentioned above and to the members of the U. of L. SAMA Executive committee for their work and cooperation which have made my task particularly light and rewarding.

Last, but by no means least, my humble appreciation to Mrs. Pat Masters of the Journal staff for her timely monthly reminders of the deadline date for this column and her indulgence concerning my frequent lack of punctuality and my editorial verbosity; and to my beloved wife Eleanor who has managed to keep the baby quiet and maintain her own equanimity while her irritable husband suffered the labor pains associated with the spawning of these many words over the past nine months.

Thanks again to all of you—it has been a tremendous amount of fun for me!

W. Neville Caudill, President
U. of L. Chapter, SAMA

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Medical Director

ROBERT L. CRAIG, M.D.
Associate Medical Director

JOHN D. PATTON, M.D.
Clinical Director



Kentucky Colonel commissions which they received at a dinner in Glasgow are displayed by—(Seated—left to right)—Herbert G. Davis, M.D., Glasgow; L. C. Biggers, M.D., Temple Hill; Clement V. Hiestand, M.D., Campbellsville; (Standing—left to right)—W. F. Owsley, M.D., Burkesville; C. G. Depp, M.D., Hiseville; Leslie Richey, M.D., Park City; and the host, C. C. Howard, M.D., Glasgow. W. J. Shacklette, M.D., Hodgenville, was ill and was unable to attend.

Medicare Contract to be Reviewed by KSMA in June

O. L. Higdon, M.D., Paducah, chairman of the KSMA Committee on Federal Medical Services, has announced that the current Medicare contract with the Department of Defense will be reviewed in June.

Any KSMA member who has any question or suggestion about the Association's contract with the government or the fee schedule covering services rendered to dependents of military personnel are asked to contact the KSMA Headquarters Office before June 1.

Doctor Higdon has asked that all requests be presented in writing.

Seven M.D.'s Over 80 Honored in Glasgow by Dr. Howard

Seven south central Kentuckians all over 80 years of age and representing 413 years of medical practice were honored at an appreciation dinner given by C. C. Howard, M.D., Glasgow, assisted by the Barren County Medical Society.

Honored were: L. C. Biggers, M.D., 88, Temple Hill; Herbert G. Davis, M.D., 84, Glasgow; C. G. Depp, M.D., 83, Hiseville; Leslie Richey, M.D., 86, Park City; W. J. Shacklette, M.D., 88, Hodgenville; Clement V. Hiestand, M.D., 88, Campbellsville; and W. F. Owsley, M.D., 81, Burkesville. Doctor Howard presented a Kentucky Colonel's commission to each physician. All of them have served their area as physicians for over 50 years and continue to do so.

Typical of the spirit of the program were these comments by a Mrs. Wykert, from Ohio, whose son is studying medicine. She said, "And to you honored here today, I think of no greater tribute than this: May all young men follow you in this kind of dream. May they serve as you have served."

Senior Citizens' Week in Ky. Begins May 10

During Senior Citizens' Week in Kentucky, May 10-17, KSMA members are urged to give thought to the problems and responsibilities connected with the increasing number of citizens in the upper age brackets, by Robertson O. Joplin, M.D., Louisville, chairman of the KSMA Committee on Problems of the Aged.

Senior Citizens' Week is being observed in Kentucky for the first time this year. Governor A. B. Chandler has proclaimed the week to give special emphasis to this situation of increasing concern.

One of the highlights of the week will be a dinner at the Mason-Dixon Dining Room, Kentucky Fair and Exposition Center, Louisville on May 13. Interested physicians are urged to attend this dinner which will have William Fitch, director of the Committee on Aging, U. S. Department of Health, Education, and Welfare, as featured speaker. Mr. Fitch was recently appointed director of the 1961 White House

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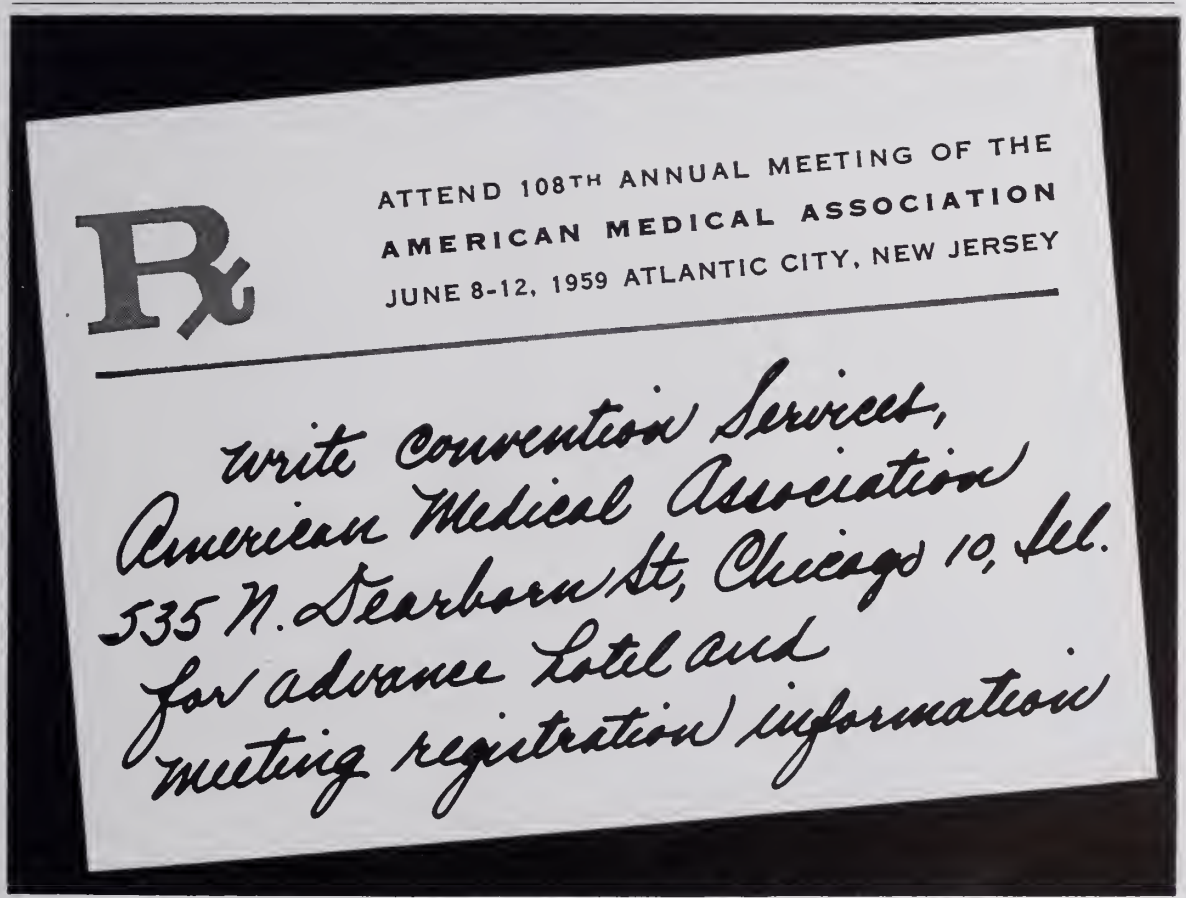
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Representatives of the Mason County Medical Society—Chadwick W. Christine, M.D., and Harold N. Parker, M.D., Maysville—are pictured at the joint meeting of the KSMA's Ninth Councilor District and the northeastern region of the KAGP on March 25 with J. M. Stevenson, M.D., Brooksville, district councilor; and Robert W. Robertson, M.D., Paducah, KSMA president.

Conference on Aging.

General Chairman of Senior Citizens' Week is Dorcas Ruthenburg, director of public affairs for WHAS, Radio.

Fee Schedule for UK Med. School Set by Trustees

The fee schedule for students attending the University of Kentucky College of Medicine has been set by The Board of Trustees at $500 annually for residents of Kentucky and $950 annually for non-residents, according to an announcement from William R. Willard, M.D., vice president of the Medical Center.

In a recent "progress report" Doctor Willard also stated that the Medical Center staff has grown from two persons to 58 persons, including about 18 transferred from the health service. Not all of the staff are on the job yet, but those who are there are engaged in a wide variety of planning, recruiting, research and service activities.

As a result of some of the research activities conducted by the staff, the University of Kentucky Hospital is being designed according to a "progressive care" concept with special provisions for patients who are critically ill, other areas for the average hospital patient, and still others for ambulant patients or those requiring only minimal care. Commenting on the new concept, Dean Willard said, "Up to this time, few major hospitals, and none related to a medical school, have been designed according to this concept."

Dr. Bosworth Heads Urologists

N. Lewis Bosworth, M.D., Lexington, is the new president-elect of the Southeastern Section of the American Urological Association. He was elected on April 1 during the group's annual meeting in Louisville.

Doctor Bosworth is a past vice president of the KSMA, past president of the Fayette County Medical Society, and presently chairman of the KSMA Committee on Public Information and Service. Others elected are: president, Rudolph Bell, M.D., Thomasville, Ga.; secretary, James L. Campbell, M.D., Orlando, Fla.; and treasurer, Hubert K. Turley, M.D., Memphis.

Cancer Grant Awarded Dr. Drye

A $57,000 grant for cancer research over a four-year period has been awarded to James C. Drye, M.D., professor of surgery at the University of Louisville School of Medicine. It was awarded by the National Cancer Institute, an agency of the U. S. Public Health Service at Bethesda, Md.

Doctor Drye will study free cancer cells in the blood of cancer patients taking treatment with drugs, surgery, and radiation. He will be aided by Condict Moore, M.D., instructor in surgery, and other personnel not yet chosen. Doctor Drye is also medical director of the Cancer Cytology Laboratory and of the Kentucky Division, American Cancer Society.

Mrs. Wallace Gets KAGP Post

Elizabeth M. Wallace, Louisville, has been named executive secretary of the Kentucky Chapter, American Academy of General Practice, effective May 1. She succeeds Clayton L. Scroggins, Cincinnati, whose business-management firm has served as the KAGP office for four years.

The New Headquarters office of the KAGP is in the Medical Arts Building, Louisville. Mrs. Wallace was formerly a member of the staff of the KSMA. A native of St. Louis, she has also been a legal secretary, a public health worker, and has been affiliated with the Adult Extension Division of the University of Kentucky.

Mental Health Research Started

A unique state-by-state study of mental health research in the Southern region has been launched by the mental health program of the Southern Regional Education Board. Under the new program research chairman for the State of Kentucky will be Harold L. McPheeters, M.D., Louisville.

In making the announcement, William P. Hurder, M.D., director of the program and the study, said, "This is perhaps the first time that a depth analysis of mental health research facilities and activities has been made in the nation or the region." The study is designed to get detailed information about the Southern region's resources and needs in mental health and behavioral science research, including research in mental retardation.

Surgeons Gather at French Lick

Surgeons from Kentucky and Indiana will be traveling to French Lick for the joint meeting of the Kentucky Surgical Society and the Kentucky and Indiana Chapters of the American College of Surgeons on May 15-16.

Full program of the meeting was carried in the April issue of the Journal. Melvin Bernhard, M.D., and William T. Rumage, Jr., M.D., both of Louisville, are program chairmen for the meeting.

Experienced M. D. starting residency in October at Mayo Clinic wishes to work during summer months for GP wishing to take vacation or as assistant.

If interested please write:

Box A, Ky. State Medical Association,
1169 Eastern Parkway
Louisville, Ky.

The Cornell University Medical College has announced its fourth annual Postgraduate Course in Fractures and Other Trauma in New York City on June 8-13 under the direction of Preston A. Wade, M.D., New York. Fifty-one different subjects in the field will be discussed during the five day meeting. Tuition is $150 and living accommodations for physicians and their wives will be available in Olin Hall, the Medical College Student Residence. For the full program and further information write to: Preston A. Wade, M.D., Cornell University Medical College, 1300 York Avenue, New York 21.

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SIGN OF GOOD TASTE



Leaders of the Woman's Auxiliary got together at a recent meeting in Louisville. From left to right are—Mrs. J. Andrew Bowen, Louisville, immediate past president; Mrs. Jesse Funk, Bowling Green, president; and Mrs. Charles Johnson, Russell, president-elect.

National Hospital Week, May 10-16

The nation's hospitals, through the American Hospital Association, have invited the medical profession to help them develop a greater understanding and appreciation of their services and contributions to the American people.

"More Roads to Recovery" will be the theme of this year's National Hospital Week on May 10-16. An explanation of these "roads"—better care, improved techniques and skills and the dramatic successes of medical science—will be aimed at helping to offset a growing myth that hospital costs are greater than the services received.

Radiation Meet Set for May 13-14

Industrial applications of ionizing radiation will be considered at the first Industrial Radiation Conference, sponsored jointly by the Department of Physics, University of Louisville, and the State Department of Health at Appliance Park on May 13 and 14.

Among the speakers will be Russell Teague, M.D., Commissioner of Health who will speak on "Radiological Health Activities—State of Kentucky" and Jesshill Love, M.D., who will talk on "The Medical Uses of Radiation."

Pediatric Group to Meet

Pediatricians throughout Kentucky are reminded that there will be a meeting of the Kentucky Chapter, American Academy of Pediatrics in Louisville on May 14, by Joseph Little, M.D., Louisville, program chairman.

The sessions will start at 3 p. m. at Children's Hospital and the evening session starting at 6:30 p.m. will be at the Medical Arts Building. Full program of the meeting was in the April issue of the Journal.

Dept. Chairman Named at UK

Joseph B. Parker, Jr., M.D., associate professor of psychiatry at the Duke University School of Medicine and chief of psychiatric service at the Durham, N. C., Veterans Hospital, has been named professor and chairman of the department of psychiatry at the University of Kentucky College of Medicine, effective July 1.

Doctor Parker is a native of Tennessee and received his medical degree from the University of Tennessee Medical School in 1941. He served his residency at Duke where he held a fellowship in neuropsychiatry. He has also done postgraduate work in psychiatry at St. Elizabeth's Hospital and has served on both the Duke and Tennessee faculties.

65 Attend 13th Dist. Meeting

Sixty-five physicians and their wives attended the meeting of the KSMA's Thirteenth Councilor District and District Four State TB Hospital at Ashland on April 9.

Featured on the program were three out-of-state physicians and Robert W. Robertson, M.D., Paducah, KSMA president. Presenting the scientific portion of the program were Roland Burns, M.D., Huntington, W. Va.; Joseph Stocklen, M.D., Cleveland, Ohio; and J. Wallace Davis, M.D., Philadelphia, Pa.

Eleven Added to KSMA Roster

Names of new members of the KSMA received as the Journal goes to press include:

Bruce Baker, M.D., Madisonville
W. L. Cawood, M.D., Ashland
E. R. Davis, M.D., Owingsville
W. L. Donham, M.D., Middlesboro
Alfred E. Jaunzems, M.D., London
Malcolm King, M.D., Paris
N. H. Talley, M.D., Princeton
Thomas Vecchio, M.D., Middlesboro
Jesse L. Walker, M.D., Middlesboro
William G. West, Jr., M.D., Madisonville
Lewis E. Wesley, M.D., Liberty



Pictured at the luncheon during the County Society Officers Conference are President-Elect Irvin Abell, Jr., M.D., Louisville; Russell Roth, M.D., Erie, Pa., guest speaker; and President Robert W. Robertson, M.D., Paducah.



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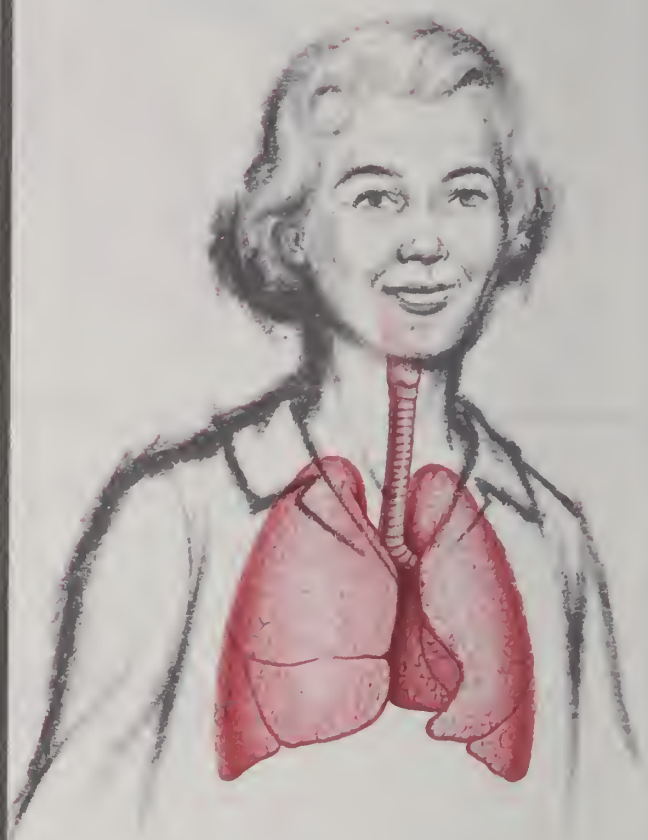
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Racephedrine Hydrochloride	30 mg.
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Niacinamide	40 mg.

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Getting together at the meeting of the Fourteenth Councilor District in Pikeville on April 8 are—left to right—Robert W. Robertson, M.D., Paducah, KSMA president; William F. Clarke, M.D., Pikeville; Mervel Hanes, M.D., Louisville, scientific essayists; Charles Rutledge, M.D., Hazard, councilor for the 14th District; Everett H. Sanneman, M.D., Louisville, scientific essayist; William C. Hambley, M.D., Pikeville, president of the Pike County Medical Society; and J. Thomas Giannini, M.D., Louisville, scientific essayist.

Pikeville Meet Attracts 55

Fifty-five physicians and their wives attended the meeting of the KSMA's Fourteenth Councilor District on April 8, according to District Councilor Charles C. Rutledge, Hazard.

Robert W. Robertson, M.D., Paducah, was featured after-dinner speaker and three Louisville physicians presented the scientific portion of the program. On the scientific program were J. Thomas Giannini, M.D., Mervel Hanes, M.D., and Everett Sanneman, M.D.

NEWS ITEMS

George Edward Dodson, M.D., has become associated with the Trover Clinic in Madisonville where he will limit his practice to obstetrics and gynecology. A native of Oklahoma, he graduated from Temple University Medical School in Philadelphia in 1953, interned at Los Angeles County General Hospital and took his residency at the Temple University Medical School and Hospital. He was in the U. S. Army as a Captain from 1941-45.

Donald I. George, M.D., has started the practice of neuropsychiatry in Lexington. A graduate of the University of Pittsburgh Medical School in 1945, he interned at Conemaugh Valley Memorial Hospital, and took his residency training at Coatesville VA Hospital. He is a diplomate of the American Board of Psychiatry and Neurology.

James R. Feild, M.D., has started the general practice of medicine in Albany. A native of Memphis, Tennessee, he graduated from the University of Tennessee Medical School in 1957 and interned at John Gaston Hospital, Memphis, in 1958.

Kingman G. Seiler, M.D., has joined the Melber Clinic, in Melber where he will engage in the general practice of medicine. Doctor Seiler graduated from the University of Louisville School of Medicine in 1943. He interned at Detroit Receiving Hospital and took residency training at Norton Memorial Infirmary, Kosair Crippled Children's Hospital and Illinois Masonic.

Giles L. Stephens, M.D., has started the practice of general surgery in the Medical Arts Building, Louisville. Doctor Stephens graduated from the University of Louisville School of Medicine in 1952, interned at St. Joseph Infirmary and took his residency training at Louisville Veterans Administration Hospital where he was chief resident in general surgery in 1957-58. From 1953-54 he was in general practice in Grayson. He is a diplomate of the American Board of Surgery.

Roy B. McEndre, M.D., has opened an office in Lewisburg for the general practice of medicine. Doctor McEndre, a native of Covington, graduated from the University of Louisville School of Medicine in 1955. He interned at St. Elizabeth Hospital in Dayton, Ohio, and then served two years in obstetrics and gynecology at the U. S. Army Hospital, Fort Campbell, Ky. He was a major.

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1959 Annual Meeting — Kentucky State Medical Association

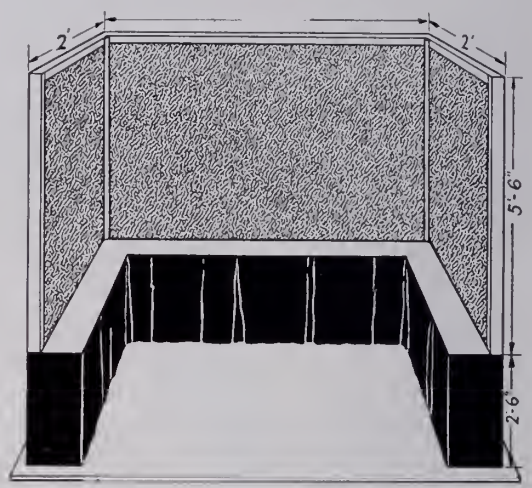
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Committee on Scientific Exhibits
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4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

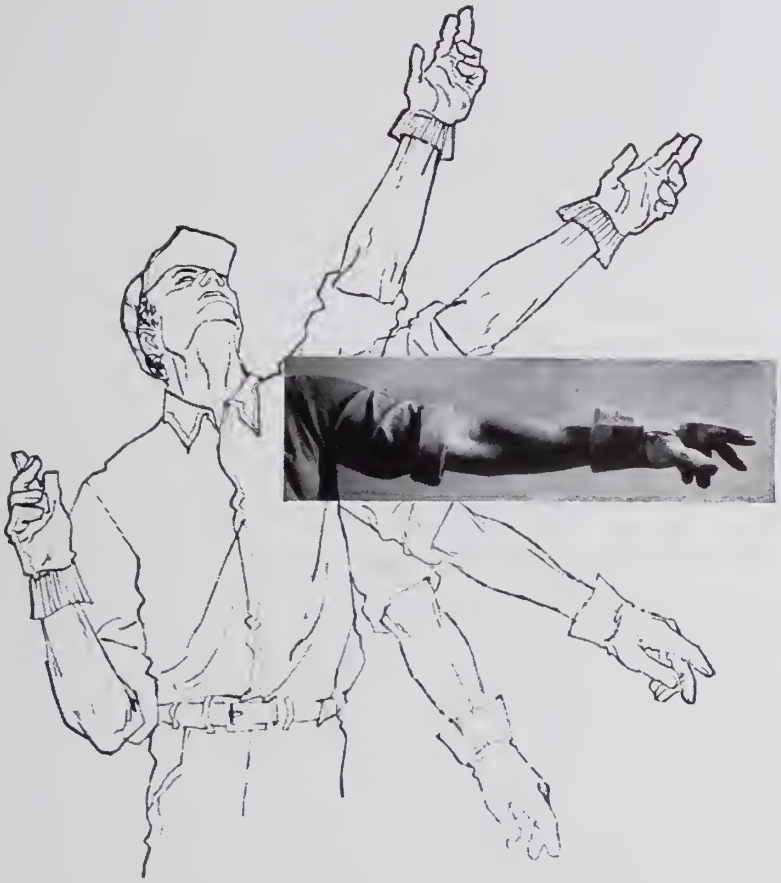
6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF. — METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

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BONADOXIN®

(tablets and drops)

STOPS STOPS STOPS MORNING SICKNESS



BONADOXIN Tablets relieve nausea and vomiting of pregnancy in 9 out of 10,[1-7] often within a few hours.

Moreover, a controlled study of 620 cases reported that with BONADOXIN "toxicity and intolerance [are] zero."[1] BONADOXIN is rarely soporific. It is free from the risks associated with overpotent tranquilizer-antinauseants.

NOTE: BONADOXIN has also been shown highly effective in relieving nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis, and motion sickness.

Each tiny pink-and-blue BONADOXIN tablet contains:

Meclizine HCl (25 mg.) . . . for antivertiginous, antinauseant effects.

Pyridoxine HCl (50 mg.) . . . for specific metabolic replacement.

DOSAGE: usually one tablet at bedtime. Severe cases may require another dose on arising.

SUPPLIED: tiny pink-and-blue tablets, bottles of 25 and 100. Fruit-flavored, clear green syrup in 30 cc. dropper bottles.

Infant colic? BONADOXIN DROPS are antispasmodic...stop colic in 84%,[8-10] without the risk of belladonna and barbiturates.

Each cc. contains:
Meclizine dihydrochloride . . 8.33 mg.
Pyridoxine hydrochloride . . .16.67 mg.

Dosage:

under 6 months . . . . 0.5 cc.	2 or 3 times daily, on the tongue, in fruit juice or water
6 months to 2 years . . . . 1.5 to 2 cc.	
2 to 6 years . . 3 cc.	
adults and children over 6 . . . . . 1 tsp. (5 cc.)	

References: 1. Goldsmith, J. W.: Minnesota Med. 40:99 (Feb.) 1957. 2. Groskloss, H. H., et al.: Clin. Med. 2:885 (Sept.) 1955. 3. Weinberg, A., and Werner, W. E. F.: Am. Pract. & Digest Treat. 6:580 (April) 1955. 4. Crawley, C. R.: West. J. Surg. 8:463 (Aug.) 1956. 5. Tartikoff, G.: Clin. Med. 3:223 (March) 1955. 6. Dunn, R. D., and Fox, L. P.: Clinical exhibit. 7. Codling, J. W., and Lowden, R. J.: Northwest Med. 57:331 (March) 1958. 8. Dougan, H. T.: Personal communication. 9. Leonard, C. L.: Personal communication. 10. Steinberg, C. L.: Personal communication.

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Science for the World's Well-Being



Representing 144 years of service to Kentuckians these veteran physicians got together at the meeting of the 14th Councilor District at Pikeville in April. From left to right are—Owen Pigman, M.D., Whitesburg, winner of the KSMA's Outstanding General Practitioner Award in 1957, Bert Bach, M.D., Whitesburg, and Adam G. Osborne, M.D., Pikeville.

County Society Reports

Madison

Z. S. Gierlach, M.D., Lexington, spoke on "Radio Isotopes" at a recent meeting of the Madison County Medical Society in Richmond, according to Society secretary-treasurer J. Bates Henderson, M.D., Berea.

Doctor Gierlach reviewed the application of isotopes in industry, agriculture—and especially in medicine—giving both the diagnostic and therapeutic uses.

The next meeting is scheduled for April 15 in Berea.

McCracken

The February meeting of the McCracken County Medical Society was held at Boswell's Restaurant on the 25th. Walker Turner, M.D., presided.

"Thoracic Trauma" was discussed by two thoracic surgeons from Evansville, Indiana—Theodore T. Myre, M.D., and Ralph F. Carlson, M.D.

A mental health committee was appointed and will include, Rex Holland, M.D., chairman; and Harold Priddle, M.D., and Joe B. Spaulding, M.D.

J. V. Pace, M.D., announced that the House of Delegates would hold a special session in Lexington on March 26. He asked that the society decide its stand, and instruct its delegates as to how the society felt on the question of third party medicine and specifically, the questions asked by the AMA. After discussion it was voted that the delegates use their own good judgment in voting on the questions.

N. A. Parrott, M.D., announced that he had received information from the U. S. Public Health Service indicating that there was a good possibility of an influenza outbreak during this season. He requested that all patients with influenza be reported and that throat washings and blood samples be sent to the state laboratory through the local health department. He said that a nurse would be provided to collect these from patients in the home and from the laboratories of the two hospitals.



in Acne

Routine cleansing with pHisoHex augments standard acne therapy. "No patient failed to improve."[1] pHisoHex helps check the infection factor in acne. Used exclusively and frequently, it will keep the skin surface virtually sterile. Contains 3 per cent hexachlorophene.

pHisoHex®

(antibacterial detergent, nonalkaline, nonirritating, hypoallergenic)

tips the balance for superior results

Winthrop LABORATORIES
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1. Hodges, F.T.: GP 14:86, Nov., 1956.



when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1, 2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

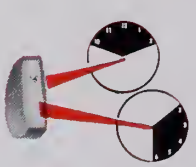
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4, 5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6, 7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.



Each TRIAMINIC timed-release tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
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Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

STOP *running noses*  *and open stuffed noses orally*

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In Memoriam

JAMES E. BARNHILL, M.D.
Owensboro
1878 - 1959

James E. Barnhill, M.D., who had practiced in Owensboro for 30 years, died at the Owensboro-Daviess County Hospital on March 30 at the age of 81.

Doctor Barnhill had been ill for several months. He was born on a farm near Philpot and attended the Louisville Medical School in 1898. He had practiced in Oklahoma and Missouri, as well as Kentucky.

CARL PARVIN COTTINGHAM, M.D.
Uniontown
1880 - 1959

Carl Parvin Cottingham, M.D., who practiced medicine in Uniontown for 40 years, died in St. Mary's Hospital in Evansville on April 8.

A native of Henderson County, he graduated from the University of Louisville Medical School in 1904. Besides actively practicing medicine, Doctor Cottingham was the past president of the Farmers Bank at Uniontown, a large-scale farmer, and had a stable of harness horses which he raced throughout the midwest.

OSCAR V. BROWN, M.D.
Island
1875-1959

Oscar V. Brown, M.D., Island, died in Owensboro-Daviess County Hospital after a long illness on March 13.

After graduating from the University of Louisville with an M.D. degree in 1904 he began practicing in Island. In 1946 he became health officer for McLean County and four years later was health officer for Ohio, continuing in both offices until his retirement in 1956. He served in the State Legislature in 1917. In 1926 he was a member of the Senate, representing Daviess and McClean counties. Doctor Brown was a native of Butler County.

CASE DISCUSSION

(Continued from page 582)

member of society. The availability and security of the Old Age and Survivor's Insurance is an insurmountable obstacle in rehabilitation of many disabled people over 50 years of age.

1. *Epstein, W. and Engleman, E. P.: "The Relation of the Rheumatoid Factor Content of Serum to Clinical Neurovascular Manifestations of Rheumatoid Arthritis." Proceedings, Annual Meeting of the American Rheumatism Association. Arthritis and Rheumatism 1, 95, 1959.*



LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions

Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

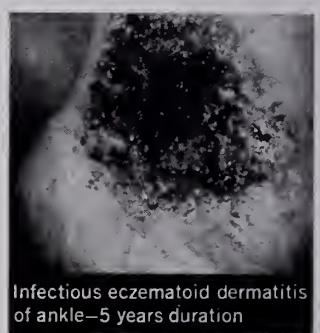
antipruritic/anti-inflammatory/antibacterial/antifungal



Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment — containing the new superior topical corticoid Kenalog — reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[8]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4] — neomycin and gramicidin for powerful antibacterial action[7] — and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.: Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

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NEWS ITEMS

William H. Carlmell, M.D., Maysville, was recently written up in his local newspaper *The Maysville Independent* as a member of the "Quarter Century Club." He was lauded for his service and pride in his profession and his community.

Four physicians, all over 85 years of age, are still actively practicing medicine in Morganfield. Combined they have a total of 223 years of medical experience. They are **J. W. Conway, M.D.,** who has had 60 years of experience; **H. B. Allen, M.D.,** who has practiced 56 years; **C. B. Graves, M.D.,** who has practiced 54 years; and **H. B. Stewart, M.D.,** 53 years.

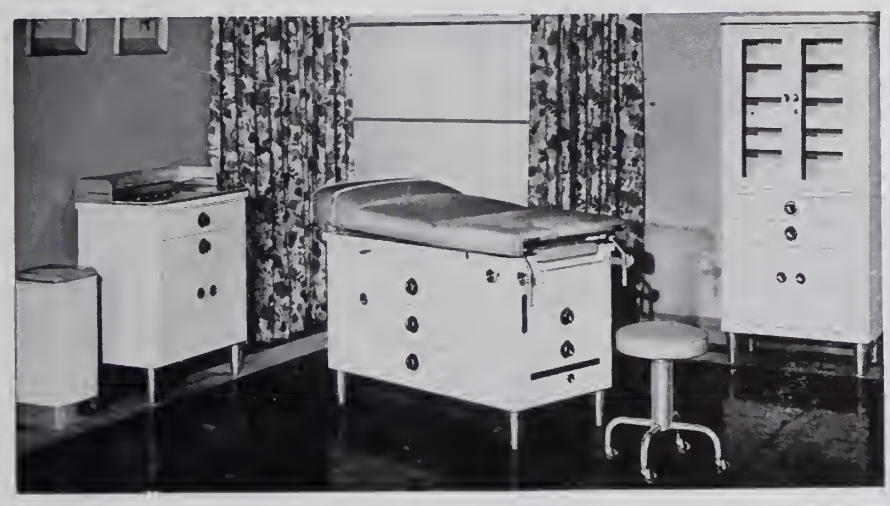
Harry Davis Abell, Jr., M.D., has opened an office in Paducah for the practice of ophthalmology. A graduate of the University of Maryland School of Medicine in 1947, he interned at St. Louis Hospital from 1947-48 and took his residency training at Johns Hopkins Hospital and spent over two years as a captain in the U. S. A. F. where he was chief of the EENT Department, Bolling Field. He also has been chief resident in ophthalmology at Western Reserve University and took a postgraduate course in ophthalmology at Western Reserve University, Cleveland.

Maj. Gen. Leonard D. Heaton, a 1926 graduate of the University of Louisville Medical School, has been nominated by President Dwight D. Eisenhower to be surgeon general of the Army. General Heaton is now commandant of Walter Reed Army Hospital in Washington. President Eisenhower was one of his patients in 1956 and Secretary of State Dulles was operated upon by Doctor Heaton for a hernia.

T. M. Radcliffe, M.D., and Edward L. Kennedy, M.D., Smithland, were honored in a program patterned after "This is Your Life" by the Lions Club of Smithland. Highlights of each doctor's life were included and they were each presented with a plaque at the end of the program. KSMA President **Robert W. Robertson, M.D., Paducah,** represented the Association at the meeting.

R. A. Purvis, M.D., has started to practice in Gilbertsville two miles south of Kentucky Dam Village State Park. He graduated from the University of Louisville Medical School in 1929 and interned at Louisville City Hospital. Doctor Purvis was in the U. S. Army Medical Corps with the rank of Captain for 13 months in 1942-43. He has formerly practiced in Greenville, Ky., and Morristown, Tenn.

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Patient A.S., age 53.
Intermittent crises of severe pain over 2 year period; hospital management with Sippy regimen provided relief of symptoms; however, symptoms recurred after each sojourn.



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Used prophylactically in anticipation of periods of emotional stress, or therapeutically to relieve tension and curb hypermotility and hypersecretion, PATHIBAMATE is particularly well-formulated for the control of gastrointestinal disorders.

PATHIBAMATE combines Meprobamate (400 mg.) — the noted tranquilizer-muscle relaxant widely accepted for safe management of tension and anxiety states — and PATHILON (25 mg.) — an extremely well-tolerated anticholinergic, long noted for prompt symptomatic relief based on peripheral atropine-like action with few side effects.

Indications:
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Supplied:
Bottles of 100 and 1,000. Each tablet (yellow, ½-scored) contains Meprobamate, 400 mg.; PATHILON Tridihexethyl Chloride, 25 mg.

Administration and Dosage:
1 tablet three times a day at mealtimes and 2 tablets at bedtime. Adjust dosage to patient response. Contraindicated in glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Also Available: PATHILON in four forms — *Tablets* of 25 mg., plain (pink) or with *phenobarbital*, 15 mg. (blue);
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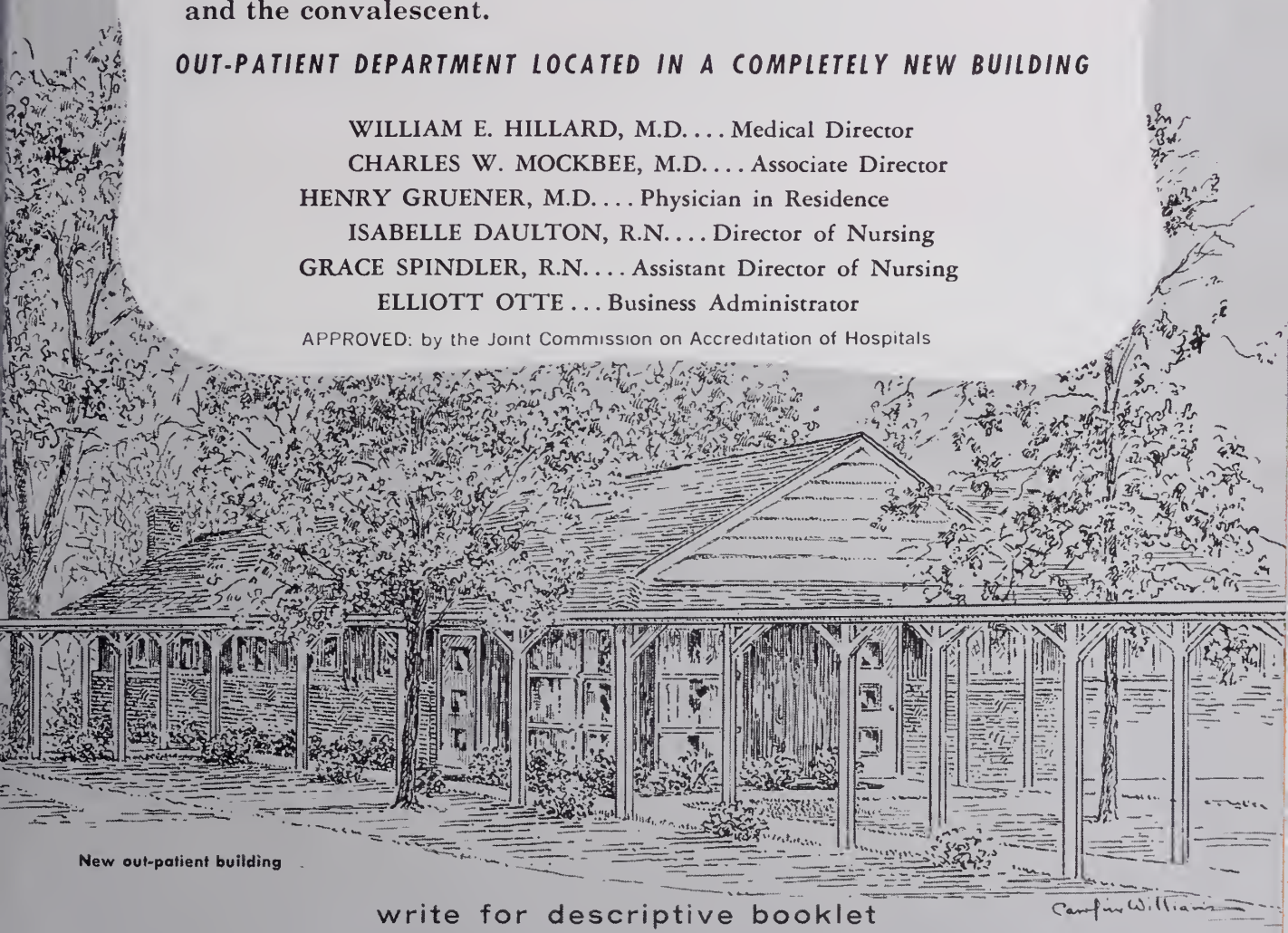
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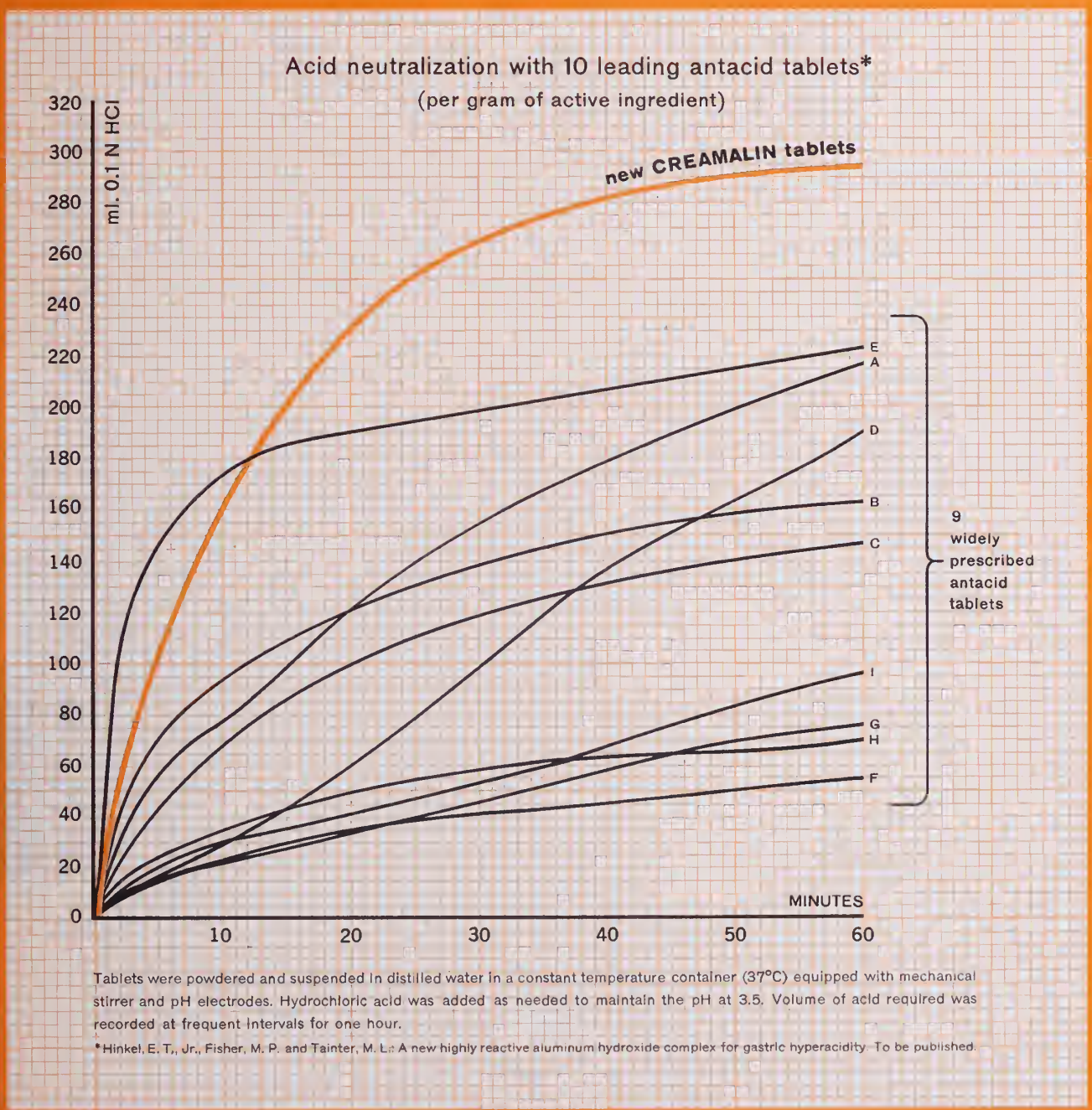
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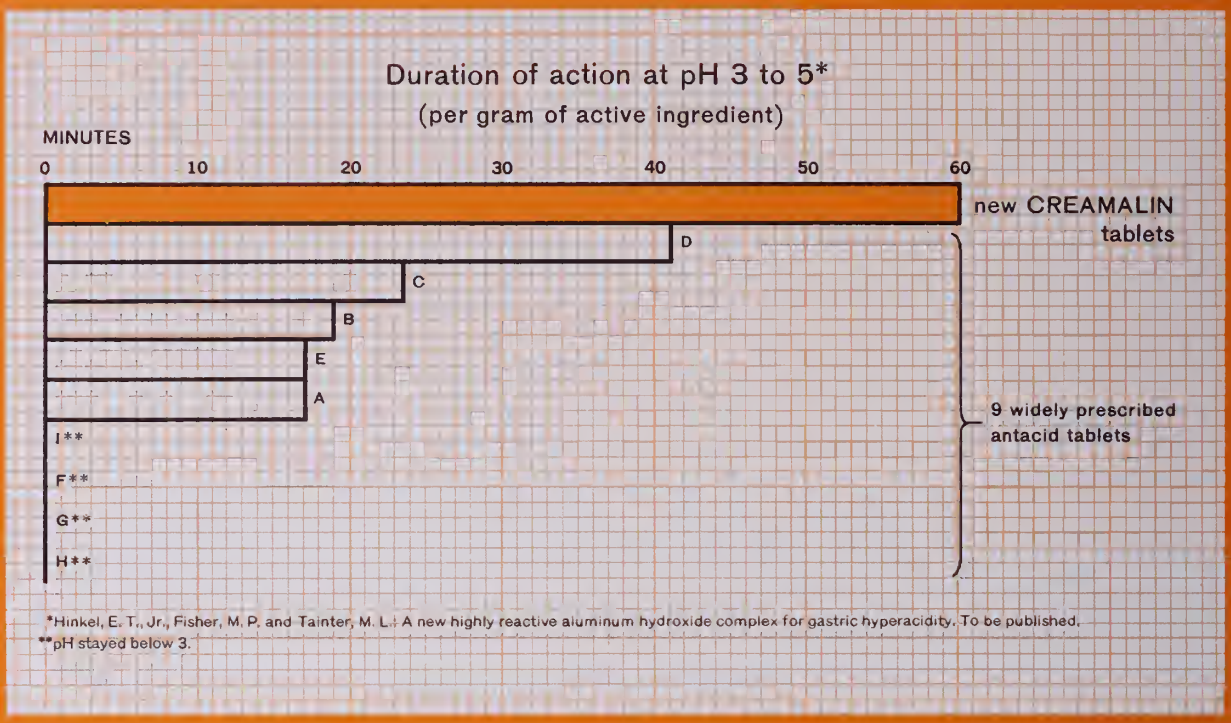


Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain the pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.

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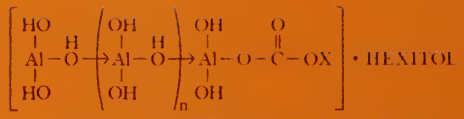
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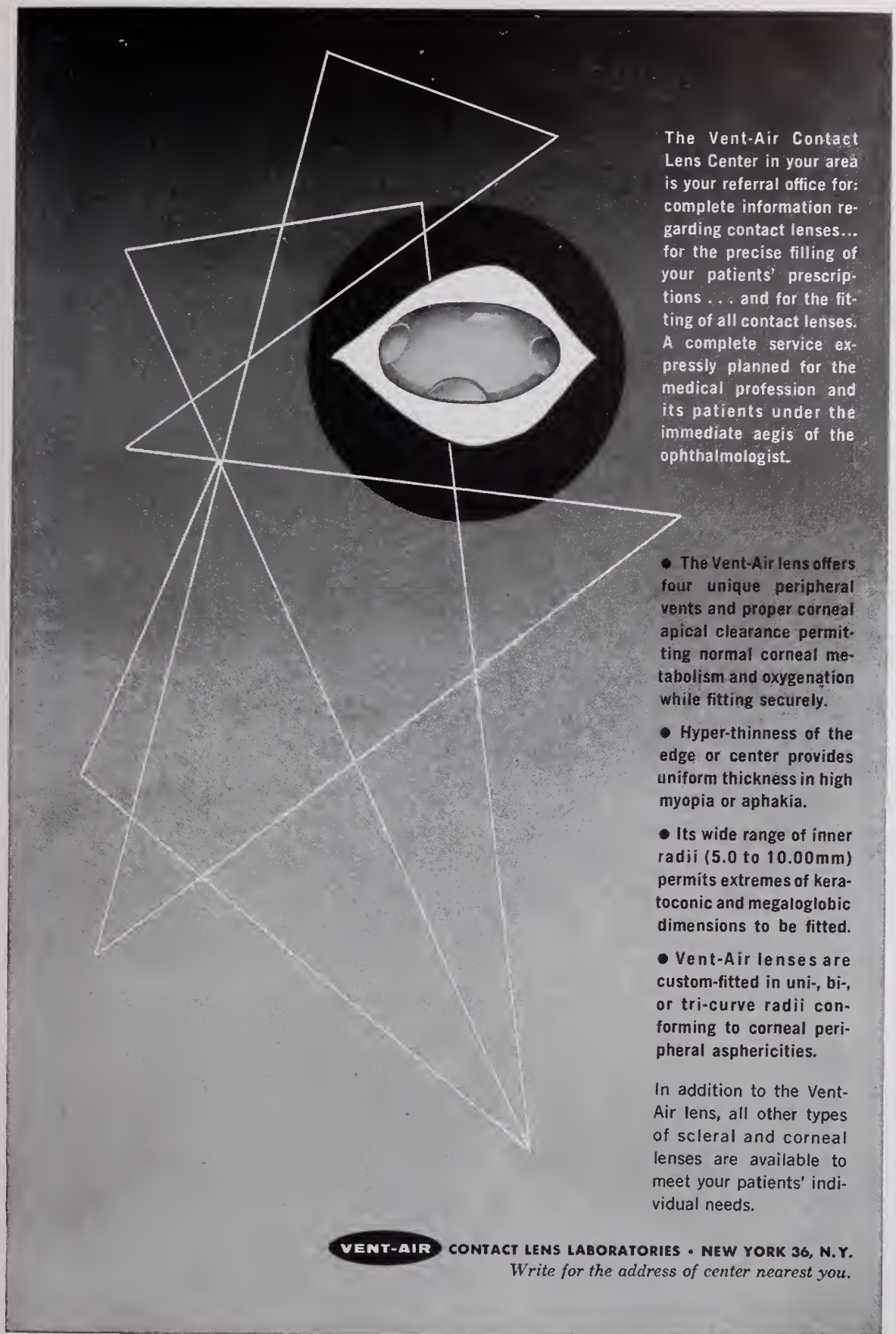
Composition: Each Creamalin Antacid Tablet contains 320 mg. specially processed, highly reactive, short polymer dried aluminum hydroxide gel, stabilized with hexitol, with 75 mg. magnesium hydroxide.

Adult Dosage: Gastric hyperacidity — 2 to 4 tablets as necessary. Peptic ulcer or gastritis — 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

Winthrop LABORATORIES · NEW YORK 18, NEW YORK

PRINTED IN U.S.A. 1331M



The Vent-Air Contact Lens Center in your area is your referral office for: complete information regarding contact lenses... for the precise filling of your patients' prescriptions . . . and for the fitting of all contact lenses. A complete service expressly planned for the medical profession and its patients under the immediate aegis of the ophthalmologist.

- The Vent-Air lens offers four unique peripheral vents and proper corneal apical clearance permitting normal corneal metabolism and oxygenation while fitting securely.
- Hyper-thinness of the edge or center provides uniform thickness in high myopia or aphakia.
- Its wide range of inner radii (5.0 to 10.00mm) permits extremes of keratoconic and megaloglobic dimensions to be fitted.
- Vent-Air lenses are custom-fitted in uni-, bi-, or tri-curve radii conforming to corneal peripheral asphericities.

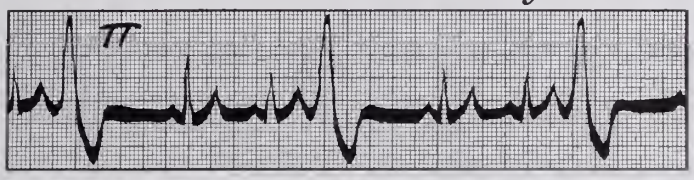
In addition to the Vent-Air lens, all other types of scleral and corneal lenses are available to meet your patients' individual needs.

VENT-AIR CONTACT LENS LABORATORIES • NEW YORK 36, N.Y.
Write for the address of center nearest you.

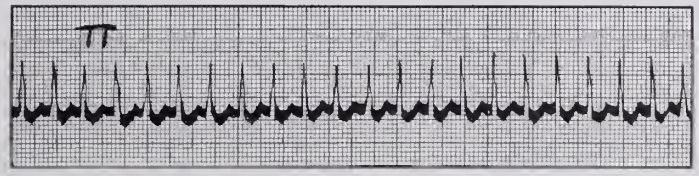
"It is concluded that the addition of buffering agents to acetylsalicylic acid in the concentrations used serves no clinically detectable useful purpose."[1]

[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.
Nonbuffered Material Used—Bayer® Aspirin.

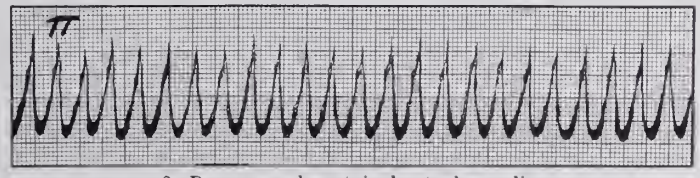
restore normal sinus rhythm



1. Premature ventricular contractions



2. Paroxysmal auricular tachycardia



3. Paroxysmal ventricular tachycardia

in arrhythmias

VISTARIL* hydroxyzine pamoate

More than a tranquilizer

SPECIFIC ANTIARRHYTHMIC EFFECT

Vistaril is effective in ventricular extrasystoles and paroxysmal tachycardias (both auricular and ventricular).

plus

PSYCHOTHERAPEUTIC POTENCY

proven calming action indicated for arrhythmia patients.

and

THE OUTSTANDING SAFETY

of Vistaril as compared to other antiarrhythmic drugs in general use has been noted by investigators.

THE FOLLOWING DOSAGE REGIMEN IS RECOMMENDED (individualized by the physician for maximum effectiveness):

PARENTERAL DOSAGE: 50-100 mg. (2-4 cc.) I.M. stat., and q. 4-6 h., p.r.n.; maintain with 25 mg. b.i.d. or t.i.d. In acute emergency, 50-75 mg. (2-3 cc.) I.V. stat.; maintain with 25-50 mg. (1-2 cc.) I.V. q. 4-6 h., p.r.n.

ORAL DOSAGE: Initially, 100 mg. daily in divided doses until arrhythmia disappears. For maintenance or prophylaxis, 50-75 mg. daily in divided doses.

SUPPLY: Vistaril Capsules, 25 mg., 50 mg. and 100 mg. Vistaril Parenteral Solution, 10 cc. vials and 2 cc. Steraject® Cartridges. Each cc. contains 25 mg. (as the hydrochloride).

Pfizer *Science for the world's well-being*

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
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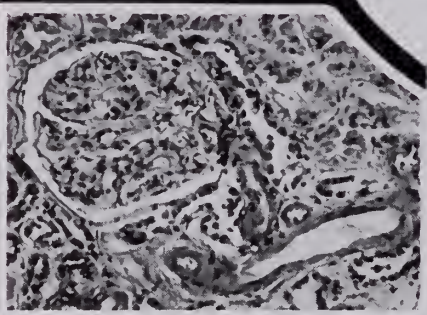
References: 1. Burrell, Z. I., et al.: Am. J. Cardiol., 1:624 (May) 1958. 2. Hutcheon, D. E., et al.: J. Pharmacol. & Exper. Therap., 118:451 (Dec.) 1956.

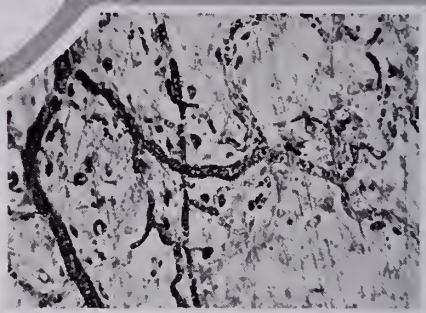
SQUIBB ANNOUNCES

NEW

RAUTRAX

RAUDIXIN
Squibb Standardized
Whole Root Rauwolfia Serpentina
FLUMETHIAZIDE
POTASSIUM CHLORIDE





A LOGICAL COMBINATION **RAUDIXIN** ENHANCED
BY AN ENTIRELY NEW DIURETIC — **FLUMETHIAZIDE**

THUS SQUIBB OFFERS YOU GREATER LATITUDE IN SOLVING THE PROBLEM OF

HYPERTENSION

WITHOUT FEAR OF SIGNIFICANT POTASSIUM DEPLETION[1-3]

Rautrax combines Raudixin with flumethiazide — *the new, safe nonmercurial diuretic* — for control of all degrees of hypertension. Clinicians report it safely and rapidly eliminates excess extracellular sodium and water without potassium depletion.[1-3] Potassium loss is less than with any other nonmercurial diuretic.[1] Moreover, the inclusion of supplemental potassium chloride in Rautrax provides added protection against potassium and chloride depletion in the long-term management of hypertension.

Through this dependable diuretic action of flumethiazide, the clinical and subclinical edema — so often associated with cardiovascular disease — is rapidly brought under control.[2-5] And once Rautrax has brought the fluid balance within normal limits, continued administration does not appreciably alter the normal serum electrolyte pattern. Flumethiazide also potentiates the antihypertensive action of Raudixin. By this unique dual action, a lower dosage of each ingredient effectively maintains safe antihypertensive therapy.

Dosage: 2 to 6 tablets daily in divided doses initially; may be adjusted within range of 1 to 6 tablets daily in divided doses. **Note:** In hypertensive patients already on ganglionic blocking agents, veratrum and/or hydralazine, the addition of Rautrax necessitates an immediate dosage reduction of these agents by at least 50%. A similar reduction is necessary when these agents are added to the Rautrax regimen.
Supply: Capsule-shaped tablets supplying 50 mg. of Raudixin, 400 mg. of flumethiazide, and 400 mg. of potassium chloride, bottles of 100.
References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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Antivert® stops



VERTIGO

Each ANTIVERT *tablet contains:*

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.[2,3]

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

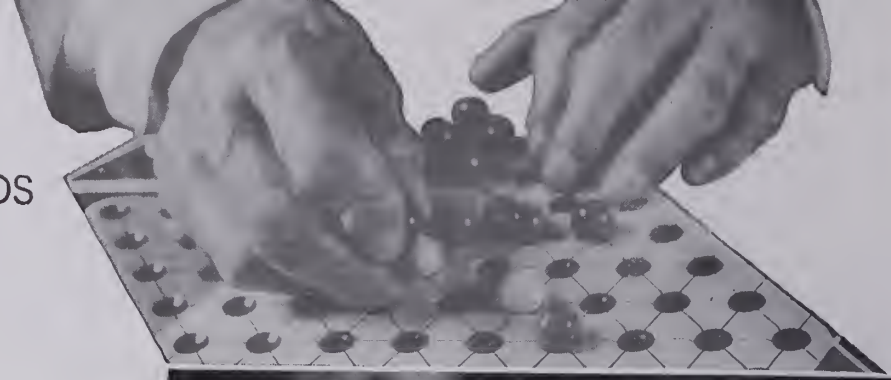
Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics *2*:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

Roerig Rx

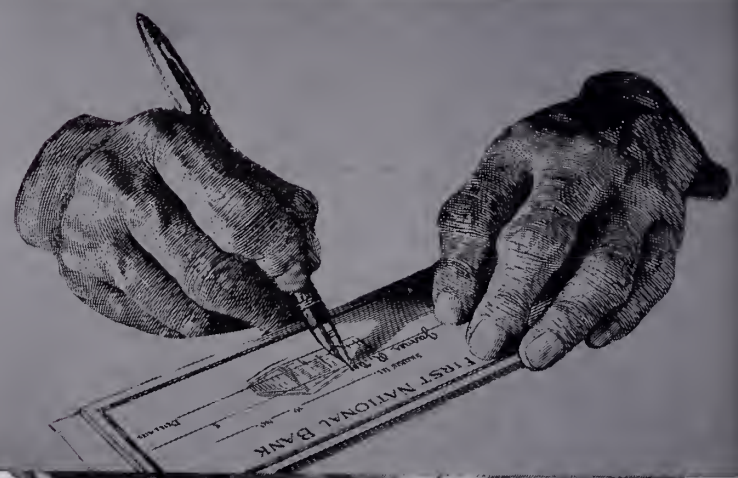
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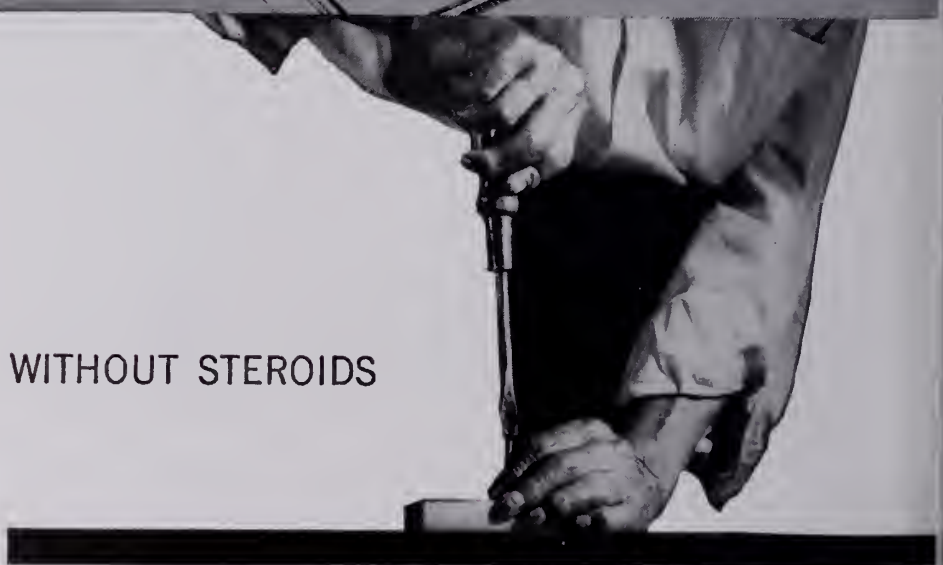
WITHOUT STEROIDS



In every arthritic state...

WITHOUT STEROIDS





WITHOUT STEROIDS

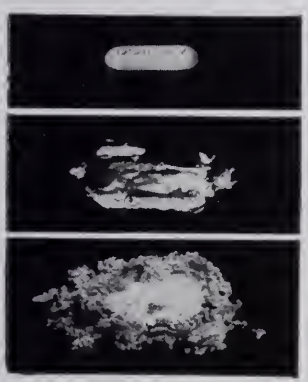
MAINTENANCE THERAPY WITHOUT STEROIDS IS FUNDAMENTAL

Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.

Buffered Pabirin provides superior maintenance therapy. It epitomizes fundamental long-term basic therapy since it can be given month after month without serious complications and with minimal problems to patient and doctor alike.

Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.



Photographs show 2-stage Tandem Release disintegration.

Each tablet contains:
Acetylsalicylic acid (5 gr.).....300 mg.
Para-aminobenzoic acid (5 gr.)....300 mg.
Ascorbic acid ..... 50 mg.
Dried aluminum hydroxide gel....100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets 3 or 4 times daily.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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re-evaluating tranquilizers?

READ WHAT CLINICIANS ARE NOW SAYING ABOUT ATARAX®

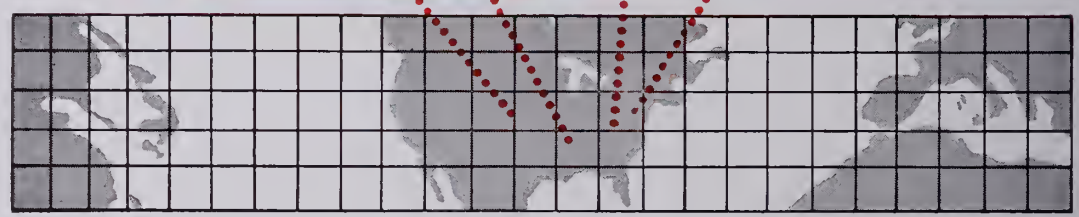
(brand of hydroxyzine)

IN GERIATRICS
"ability to decide correctly has increased, while the illogical response to anxiety has diminished."[1]

IN WORKING ADULTS
"especially well suited for ambulatory patients who must work, drive a car, or operate machinery."[3]

IN PEDIATRICS
"ATARAX appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...."[2]

IN GENERAL
ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



INVESTIGATORS AGREE ON OPTIMAL ATARAX DOSAGES

For childhood behavior disorders	10 mg. tablets Syrup	3-6 years, one tablet t.i.d. over 6 years, two tablets t.i.d. 3-6 years, one tsp. t.i.d. over 6 years, two tsp. t.i.d.
For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

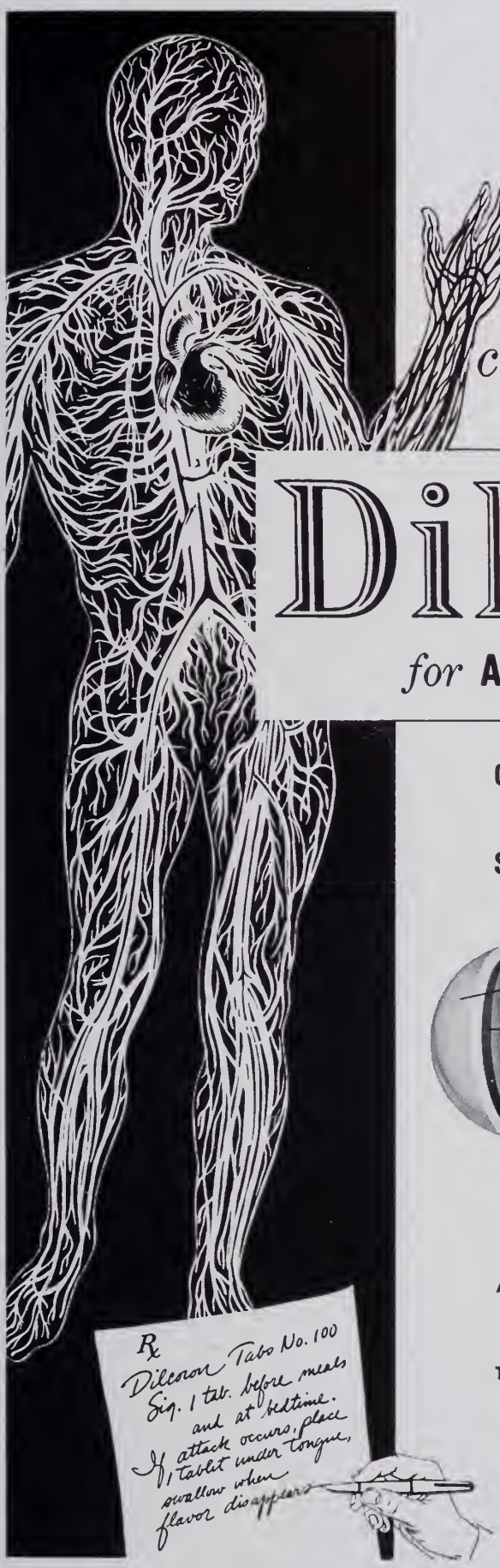
Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

ATARAX®

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Science for the World's Well-Being



NEW

"flavor-timed" dual-action coronary vasodilator

Dilcoron®

for ANGINA PECTORIS

ORAL *(tablet swallowed whole)*
for dependable prophylaxis

SUBLINGUAL-ORAL
for immediate and sustained relief



Nitroglycerin
—0.4 mg. (1/150 grain)—acts quickly

Citrus "flavor-timer"
—signals patient when to swallow

Pentaerythritol tetranitrate
—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

Bottles of 100.

Average prophylactic dose:
1 tablet four times daily
(½ hour before meals and at bedtime).

Therapeutic dose:
1 tablet held under the tongue until citrus flavor disappears, then swallowed.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

HIGHLIGHTS FROM THE A.M.A. COUNCIL ON DRUGS

REPORT ON TRIAMCINOLONE

J.A.M.A. 169:257 (January 17) 1959.

"It [triamcinolone] has an anti-inflammatory potency greater than an equal amount of prednisolone; i.e., comparable suppressive effects may usually be achieved with lower doses of triamcinolone than with prednisolone."

"Triamcinolone lacks the sodium-retaining and edema-producing effects of most other glucocorticoids. During the first several days of administration, it may cause a loss of sodium from the body; an initial mild diuretic action is frequently observed, whether the patient is frankly edematous or not. This is in contrast to the definite sodium-retaining and fluid-retaining properties of cortisone and hydrocortisone and to a much lesser extent with prednisone and prednisolone."

"Except in exceedingly large doses, triamcinolone apparently has no consistent effect on potassium excretion. Hence, neither sodium restriction nor potassium supplementation is ordinarily required during therapy with this agent."

"As with other glucocorticoids, the long-term administration of triamcinolone results in definite catabolic effects, as indicated by impairment of carbohydrate utilization and negative protein and calcium balance. This catabolic effect, coupled with a lack of appetite stimulation which is apparently peculiar to triamcinolone, may produce weight loss that might be undesirable in some patients treated for long periods of time."

"...the voracious appetite, with weight gain and euphoria, characteristic of other steroids, is not seen with administration of triamcinolone."

"Triamcinolone has been used for the management of a wide variety of clinical conditions usually considered amenable to systemic steroid therapy. These have included rheumatoid arthritis and other collagen diseases, allergic and dermatological disorders, certain leukemias and malignant lymphomas, the nephrotic syndrome, pulmonary emphysema and fibrosis, acute bursitis, rheumatic fever, and certain blood dyscrasias. Although clinical experience with the drug in some of the foregoing conditions is not extensive, the many similarities in action between triamcinolone and other potent glucocorticoids would indicate a usefulness for triamcinolone akin to that of other agents of this class."

"There is some evidence that triamcinolone is more effective at a smaller dosage than are other steroids in controlling both the skin and joint lesions in psoriasis, whether or not complicated by arthropathy."

"Triamcinolone appears to compare favorably with other steroids for use in those situations in which edema and sodium retention have been complicating problems."

"It [triamcinolone] may also be the steroid of choice for patients in whom psychic stimulation, euphoria, voracious appetite, and weight gain should be avoided."

"...the drug [triamcinolone] does produce the other side effects and untoward reactions common to the glucocorticoids. At therapeutically equivalent doses, the frequency and severity of clinical manifestations of hyperadrenalism — rounding of the face, fat deposition, and hirsutism — are essentially the same. Likewise, there is little indication that the relative incidence of osteoporosis is materially decreased after the long-term use of the drug."

"Triamcinolone apparently does not cause the euphoria sometimes seen with other steroids, and the occurrence of mental depressions is uncommon."

"Current evidence suggests that the drug [triamcinolone] may not produce as high an incidence of peptic ulcer as do other steroids."

"Cutaneous erythema seems to be a side effect peculiar to triamcinolone."

"The usual contraindications and precautions of glucocorticoid therapy should be followed in the use of triamcinolone, keeping in mind that prolonged therapy with this drug will suppress the function of the patient's own adrenals by interfering with the pituitary-adrenal axis."

Aristocort®

Triamcinolone LEDERLE

Supplied: 1 mg. scored tablets (yellow)
2 mg. scored tablets (pink)
4 mg. scored tablets (white)

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York


New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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Squibb Quality—the Priceless Ingredient

'Delalutin'® is a Squibb trademark



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PLEASANT GROVE HOSPITAL

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FOR ALL TYPES OF NERVOUS AND MENTAL DISEASES, AND ALCOHOLISM

Member of the American Hospital Association and National Association of Private Psychiatric Hospitals

Four modern buildings, separate for men and women Individual rooms. All buildings equipped with radio. Recreation.

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L. A. BUTTERFIELD,
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Registered nurses and trained personnel. Constant medical supervision. Open to members of the Medical Association.

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Robert C. Long, 806 Heyburn Building, Louisville	1960
George P. Archer, Prestonsburg (Alternate)	1960

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Brayten Pharmaceutical Co. 545
Burroughs Welcome 621
Central Pharmacal Company ..... Insert 607-608
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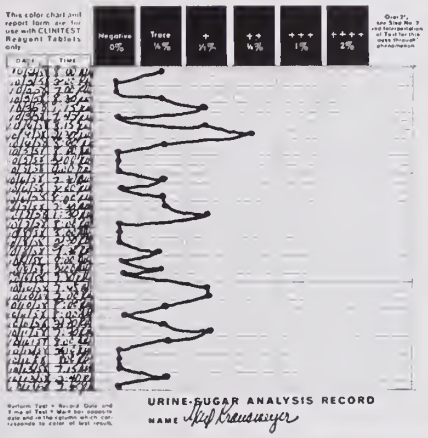
Blood sugar levels. In renal glycosuria they are normal; in untreated diabetes, fasting blood sugars are usually 130 mg.% or over and postprandial levels 170 mg.%, or more.

Source: Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 9, Philadelphia, Lea & Febiger, 1952, pp. 701-702.

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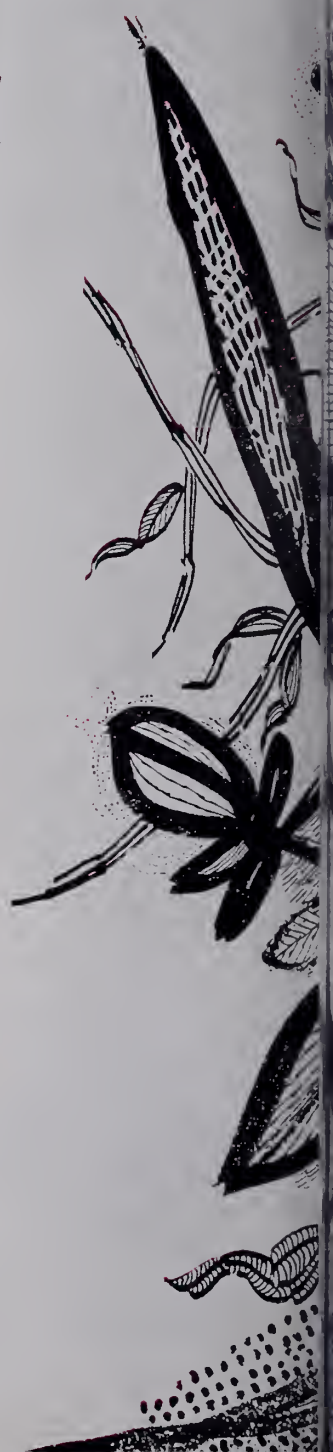
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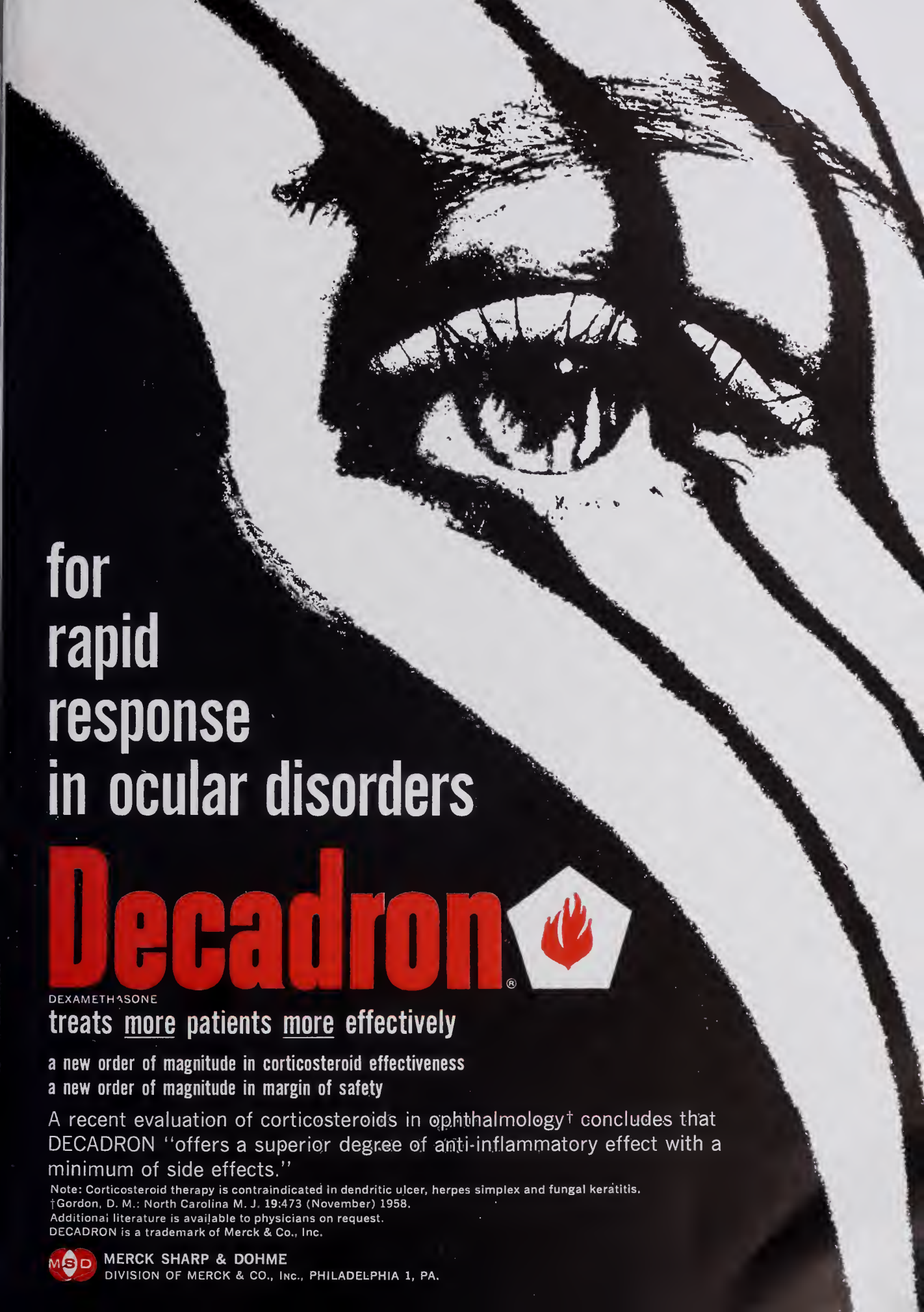
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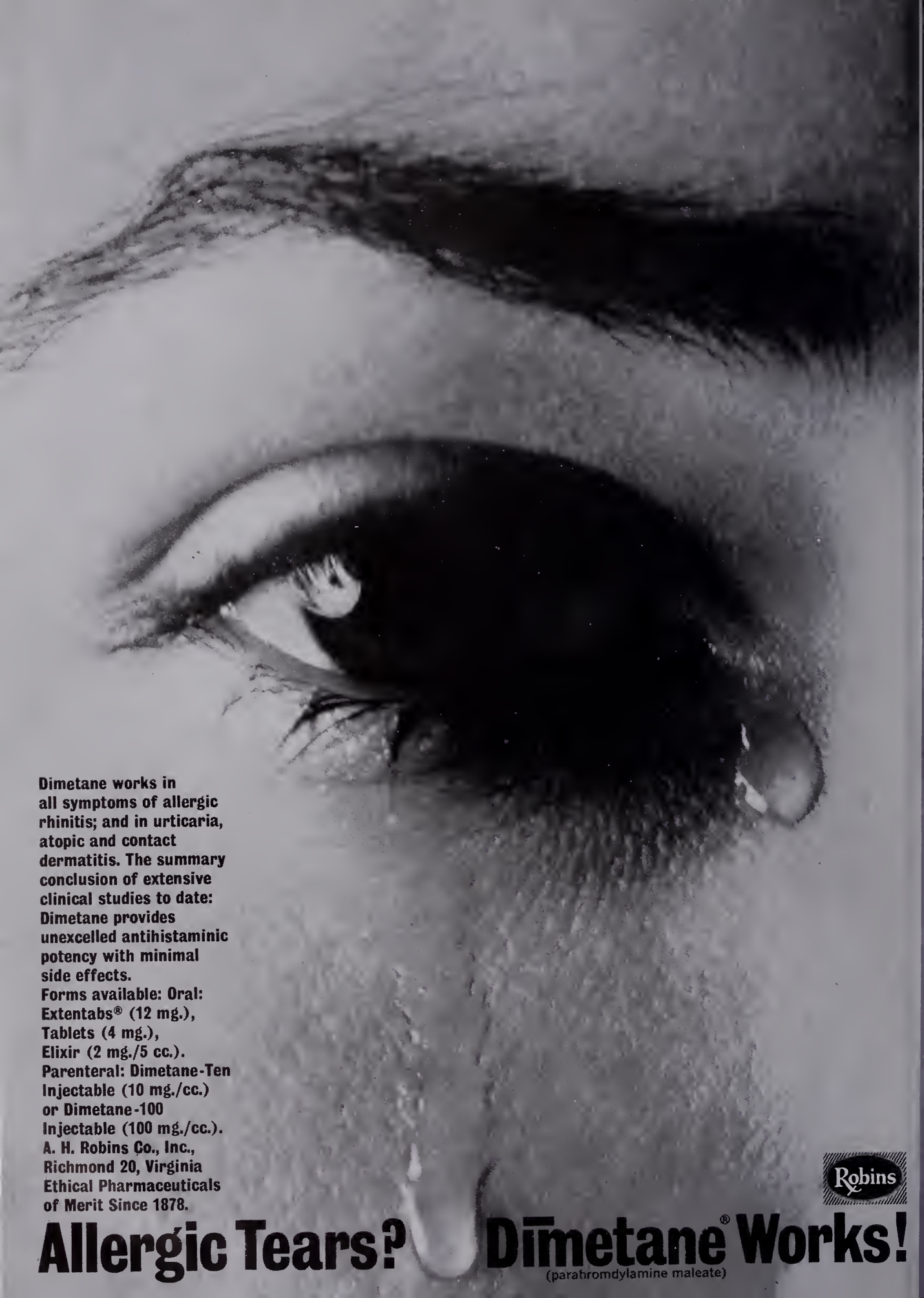
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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L. F. Beasley, M.D.
Vice President—Western

President's Page*

THE continued agitation for federally supported medical and nursing home care for people above sixty-five is enough to cause one to stop and take inventory of the course of the socialization that has taken place in the last three decades. Also the question of providing revenue for such a program is becoming so great as to defy the imagination.

Since the inception of this program it has become necessary for an ever-increasing number of women to enter employment to keep the family budget solvent as well as to provide productivity as needed. When one considers that those people principally between twenty and sixty-five are forced to produce income and products to support the population below and above sixty-five plus the disabled people of all ages, it becomes apparent that their load is getting heavy.

Now labor leaders are advocating a 35-hour week for all our labor force. There is good reason to believe they may next agitate for retirement at sixty and maybe later even at fifty-five. It is a vicious cycle that can be carried to the point of "breaking the camel's back."

The Forand bill is but another step in this direction. All these added benefits call for added taxation beyond belief. It is estimated that present benefits will call for 9 per cent social security payments in a few years.

It is to be hoped that enough people will have the insight to resist further encroachment on our national disposable income and productivity.

L. F. Beasley, M.D.
Vice President—Western Section

This is the third of a series of guest articles written by the KSMA vice presidents at the invitation of Robert W. Robertson, M.D., president.

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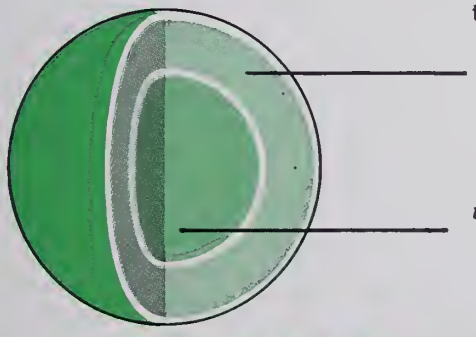
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IN THE BOOKS

PRACTICAL DERMATOLOGY: by George M. Lewis, M.D., published by W. B. Saunders Company, Philadelphia, 1959; Second edition; 363 pages; 121 plates; price, $8.

This is the second edition of this book. The first edition was published under the title *Practical Dermatology for Medical Students and General Practitioners*. Dr. George Lewis is a dermatologist who has also become one of the world's most noted mycologists. This book has 26 chapters and 350 pages.

It is not the intention of this volume to go into excessive and experimental detail regarding the various aspects of dermatology. Rather, it forms a very concise, orderly, and abbreviated description of most, if not all, of the presently known dermatological afflictions. Dr. Lewis opens his book with a very remarkable chapter on diagnostic methods, particularly emphasizing an acute and a minute dermatological history of the individual patient. He emphasizes also the fact that any new patient presenting himself to a dermatologist should receive a complete physical examination. All descriptive terms used in dermatology are explained to complete satisfaction. Each chapter is concise, and there are enough photographs of each group of dermatological disorders to very well help a person in general practice and in other fields of the practice of medicine besides dermatology.

All dermatological afflictions that can be grouped into one chapter heading have been very nicely placed by Doctor Lewis. If one is looking for a pyrodermatic problem, one can look under the pyroderma chapter and probably find what one wants. Throughout the book one is impressed by first, the definition of the affliction being described, secondly, the neat and orderly description and placement of the symptoms and physical findings, and thirdly, the manner in which the diagnosis with particular reference to differential diagnosis is expounded upon. He then takes up very quickly the etiological factors involved and the usual or more common type of treatment used in each case. One also is impressed by the facts that the location on the body, the usual known cause, and the better types of treatment are in heavy print as contrasted by a lighter print of the rest of the book.

Dr. Lewis very wisely included in this book a chapter on "Skin and Other Organs." In this chapter, he refers to the skin as a mirror of the human body with particular reference as to what is going on inside this body. He takes up various abnormalities found on the skin, such as Lupus Erythematosus, Leukemia, Amyloidosis, the various malignancies, Neurofibromatosis, Sarcoidosis, etc., and integrates the entire system in reference to each of these illnesses.

The last and second to the last chapters of the book are interesting in this respect. Chapter twenty-five is devoted entirely to medicaments used usually in the treatment of dermatological diseases. In this chapter Dr. Lewis has gone into extensive explanations of the various types of medicines used and how they are usually formulated. He usually gives the indications for wet dressings or dry dressings, whether heat or coldness should be used, why some agents should be used in one respect and why they should not be used in others. Along with this are many actual prescriptions that are very useful in the practice of dermatology.

The last chapter in the book is devoted to the basic sciences in relation to dermatology. In this chapter, he takes up the study of virus cultures and the study of viri, the physiology of the skin, the pathology and cell morphology more often encountered in the practice of dermatology. Naturally, being a mycologist himself, he has a very good chapter on the fungus infections of the skin and also on how to culture fungi.

This book is a very excellent short book of dermatology. It can be used both by the dermatologist for quick reference or quick information and by the general practitioners and specialists in other fields as well. The numerous photographs that are present throughout the book are particularly acutely made so that one does not have to imagine what one thing or another thing may look like. All in all it would do anyone's library a real service.

George F. McAuliffe, M.D.

CLINICAL OBSTETRICS AND GYNECOLOGY: Volume 1, Number 4, "Symposium on Operative Obstetrics," edited by Robert Willson, M.D., and "Symposium on Genital Cancer," edited by Daniel G. Morton, M.D., published by Paul B. Hoeber, Inc., December 1958; 281 pages.

Twenty-nine authors have contributed to these Symposiums on Operative Obstetrics and Genital Cancer.

Although the sections on injuries of the birth canal are elementary in scope, the emphasis directed to thorough digital exploration of the uterus and visualization of the cervix and vagina following delivery are most important in daily practice.

Breech extraction is discussed in detail, and the author's philosophy of management of this major complication of pregnancy is well organized. Elective partial breech extraction and total breech extraction are distinguished, and their relative merits and disadvantages are enumerated. The author favors elective total breech extraction in the management of most cases.

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dangers of forceps operations are reiterated in this section. Explicit instructions are given for the management of deep transverse arrest of the occiput and persistent occiput posterior positions. It is pointed out that trial forceps will make a certain number of Cesarean sections unnecessary, and that it will prevent some traumatic midforceps deliveries.

Cesarean section is discussed from the standpoint of indications, incidence, type of operation, anesthesia, and complications. In general the author favors low cervical Cesarean section and spinal anesthesia. It is unfortunate no discussion is included of vaginal delivery subsequent to previous Cesarean section.

In the second section, early diagnosis of genital carcinoma is stressed as prerequisite to its cure. It is the duty of all concerned to *look* for early lesions of the genital tract and utilize the best diagnostic aids available. The patient must also realize that carcinoma in its earlier stages does not produce symptoms. Therefore, annual examination of the vulva, vagina, cervix uteri, uterine corpus and adnexa is mandatory.

All methods of cancer detection for the genital tract are reviewed. The use of Papanicolaou smears taken from the cervix is emphasized.

Stage O or carcinoma in situ of the uterine cervix is reviewed in relation to its definitive treatment. This represents a tremendous step forward, for women with stage O carcinoma can avoid the hazards of full-blown cancer and, with rare exception, can be definitely cured.

Radiation treatment of invasive cervical cancer is described as a precise technique. The author of this section believes that radical surgery has its greatest application in the radioresistant lesions.

The author of the section on radical hysterectomy with bilateral pelvic lymph node dissection states their surgical treatment has been most effective, especially in those patients in whom radiation resistance can be detected by Graham's method.

Radical operation for recurrent gynecologic cancer, and the treatment of pelvic malignancies with radioisotopes are discussed in general terms.

The diagnosis and management of malignancies of the endometrium, ovary, Fallopian tube, vulva, and vagina are reviewed by experts in their respective fields.

Finally, the complications of treatment of pelvic cancer by surgery and irradition therapy are discussed. The urinary tract and lower bowel are most frequently affected.

William E. Pugh, M.D.

A COMPENDIUM OF RESEARCH AND THEORY ON STUTTERING: by Charles F. Diehl, Ph. D., published by Charles C. Thomas, Springfield, Ill.; 1959, 313 pages, price, $9.75.

It was the author's intent to organize into one volume for easy reference the wealth of material which has been published on the problems of stuttering. The material has been classified into five units starting with historical theories, followed by studies on stuttering symptoms, on physiological causality, on psychological factors as the cause of stuttering, and finally by a unit on the various approaches to therapy. The method of organization is entirely logical and would appeal to the student if the book were to be used as a text or to the experienced person using it as a reference source.

The great majority of studies reported are experimental, and the results are presented in such a way that they can be critically evaluated according to the usual criteria for scientific investigation. The highlighting of procedures and data facilitates such evaluation.

Coverage of the periodical literature for selection of articles to be presented has been exhaustive, and the choice of articles to give a wide range of approaches to the problem, as well as some depth, is excellent. In addition to the studies which are examined in detail, additional references are listed for more complete investigation of particular topics.

Professor Diehl is to be commended for a significant contribution to the literature in the area of speech disorders. He has accomplished the Herculean task of surveying a field of study, selecting the significant and pointing out its significance, classifying the material, and of organizing it into usable form.

The individual who is turning his attention to the problem of stuttering for the first time may be a bit confused by the divergent theories and by the conflicting research findings which are presented. However, those individuals who are acquainted with the problem will find the volume of inestimable value in extending their knowledge. For those individuals who are already well-versed in the area and who are contemplating research, the volume will greatly facilitate their efforts. In addition, it will promote interest in stuttering because of the wealth of material which it offers to even casual perusal, and it undoubtedly will stimulate further research.

Edmond F. Erwin, Ph.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

DISEASES OF METABOLISM: by Garfield G. Duncan, M.D., published by W. B. Saunders Company, Philadelphia and London.

FUNDAMENTALS OF OTOLARYNGOLOGY: by Lawrence R. Boies, M.D., published by W. B. Saunders Company, Philadelphia and London.

GENERAL UROLOGY: by Donald R. Smith, M.D., second edition, published by Lange Medical Publications, Los Altos, Calif.

GYNECOLOGIC ENDOCRINOLOGY: by Gardner M. Riley, M.D., published by Paul B. Hoeber, Inc., New York, N. Y.

SURGERY IN WORLD WAR II: Neurosurgery, Volume 1: from the Medical Dept. of the U. S. Army, prepared under the direction of the Surgeon General, Washington, D. C.



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G. Tivis Graves, Jr., M. D.
Associate Director



might Colace have prevented this?

As Dennison[1] reported, *"It is our considered opinion that the relief from straining at the stool is, in many instances, life-saving." And, further, "In the handling of bowel problems in cardiac patients, the properties of dioctyl sodium sulfosuccinate closely approach those required of an ideal agent."*

Colace®

Dioctyl sodium sulfosuccinate, Mead Johnson

prevents hard, difficult-to-pass stools . . . without laxative action.

available in 3 convenient dosage forms:
capsules (50 and 100 mg.) . . . for adults and older children
syrup . . . for children and adults
liquid (drops) . . . for infants and children

Mead Johnson
Symbol of service in medicine

1. Dennison, A.D., Jr.: Am. J. Cardiol. 400-403 (March) 1958.

AC-259 M

Antivert® stops



VERTIGO

Each ANTIVERT *tablet contains:*

Meclizine (12.5 mg.)—most effective antihistaminic to control vestibular dysfunction.[1]

Nicotinic acid (50 mg.)—the drug of choice for prompt vasodilation.[2,3]

Advantage of "dual therapy" confirmed:

Menger found ANTIVERT "improved or controlled symptoms in virtually 90% of vertiginous patients."[2]

Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics 2:110 (March) 1956. 2. Menger, H. C.: Clin. Med. *4*:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America *40*:1787 (Nov.) 1956.

ROERIG Rx

Division, Chas. Pfizer & Co., Inc.
New York 17, N. Y.
Science for the world's well-being

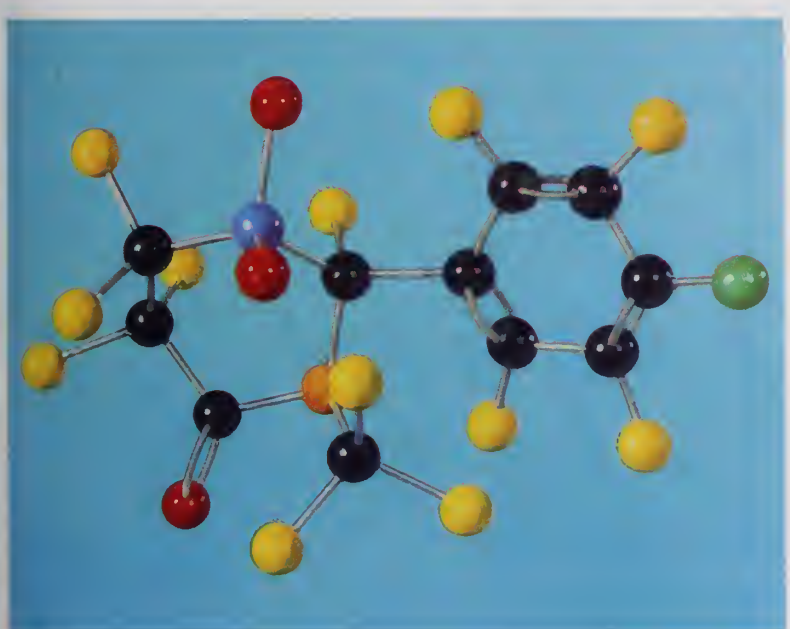
for
low back pain
and
dysmenorrhea

Trancopal®

*the first true tranquilaxant**

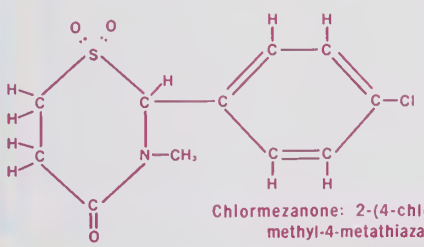
***Potent* MUSCLE RELAXANT**
***... Equally effective as a* TRANQUILIZER**

***tran-qui-lax-ant** (tran'kwi-lak'sant) [< L. tranquillus, quiet; L. laxare, to loosen, as the muscles]



Trancopal, a major development of Winthrop research, is a new, orally administered nonhypnotic central relaxant and tranquilizer. It relieves muscle spasm in a variety of musculoskeletal and neurologic conditions and also exerts a marked tranquilizing effect in anxiety and tension states.

Unrelated chemically to any other drug in current use, Trancopal offers a completely new major chemical contribution to therapeutics.



Chlormezanone: 2-(4-chlorophenyl)-3-methyl-4-metathiazanone-1-dioxide

Clinical studies of over 4400 patients by 105 physicians[1] proved Trancopal remarkably effective in musculoskeletal conditions, anxiety and tension states.

MUSCULOSKELETAL DISORDERS

effective in

93%

of 1570 documented cases of

LOW BACK PAIN

(LUMBACO, SACROILIAC DISORDERS)

By relieving muscle spasm and pain, Trancopal permits early and active exercise and physical therapy to accomplish maximal benefits for rapid recovery.

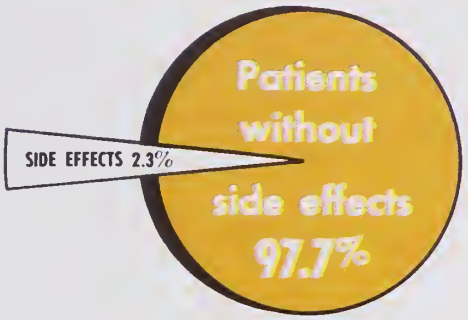
Trancopal

the first true tranquilaxant

BETTER TOLERATED AND SAFER THAN OLDER DRUGS

With Trancopal there is no clouding of consciousness, no euphoria or depression. Even in high dosage, there is no perceptible soporific effect. Because it does not irritate gastric mucosa, it can be taken without regard to mealtimes. Administration does not hamper work—or play. Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. Toxicity is extremely low. And Trancopal has a lower incidence of side effects than has zoxazolamine, methocarbamol or meprobamate.

INCIDENCE OF SIDE EFFECTS WITH TRANCOPAL IN 4483 PATIENTS



ANXIETY AND TENSION STATES

effective in

88%

of 443 documented cases of

DYSMENORRHEA

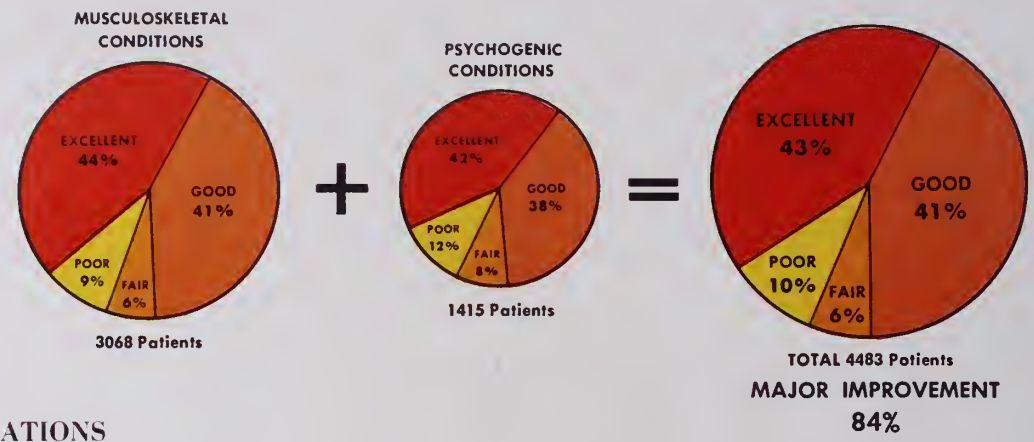
AND PREMENSTRUAL TENSION

Because of its exceptional calmative property, Trancopal "... allows the patient to use his energies in a more productive manner in overcoming his basic problems."[2]

Dosage: 1 or 2 Caplets (100 mg.) orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Thoroughly evaluated clinically...

Clinical studies of 4483 patients by 105 physicians[1] have demonstrated that Trancopal often is effective when other drugs have failed. From these studies it is evident that Trancopal can provide more help for a greater number of tense, spastic, and/or emotionally upset patients than can any other chemotherapeutic agent in current use.



INDICATIONS

Musculoskeletal

- Low back pain (lumbago)
- Neck pain (torticollis, etc.)
- Bursitis
- Rheumatoid arthritis
- Osteoarthritis
- Disk syndrome
- Fibrositis
- Ankle sprain, tennis elbow, etc.
- Myositis
- Postoperative muscle spasm

Psychogenic

- Anxiety and tension states
- Dysmenorrhea
- Premenstrual tension
- Asthma
- Angina pectoris
- Alcoholism

Supplied: Trancopal Caplets® (scored) 100 mg., bottles of 100.

References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E.: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

the first true tranquilaxant

Trancopal

Potent
MUSCLE RELAXANT
...Equally effective as a
TRANQUILIZER

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

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for
vaginal
douching
that is
physiologically
sound

ethically promoted

Meta Cine

vaginal douche powder

Meta Cine represents a carefully designed formula which provides the physician with a vaginal douche preparation which safely and effectively maintains a clean healthy vagina.

Meta Cine is a combination of several ingredients clinically established as valuable in promoting proper vaginal hygiene. Diluted for use, Meta Cine possesses the desired pH (3.5); contains the mucus digestant, papain, which dissolves mucus plugs and coagulum; contains lactose to promote growth of desirable döderlein bacilli, and methyl salicylate for soothing stimulation of circulation within the vaginal walls.

Its pleasant, deodorizing fragrance also meets the esthetic demands of your patients.

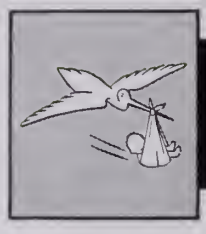
Meta Cine is promoted exclusively to the medical profession, and recommends itself as your preparation of choice for patients who might otherwise indulge in unsupervised self-medication with potentially damaging nonphysiologic douches.

Supplied in 8-oz. containers. 2 teaspoonfuls in 2 quarts of warm water, douche as prescribed.

Printed douching instructions for patients available upon request.



BRAYTEN Pharmaceutical Company • *Chattanooga 9, Tennessee*



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Case #25: This patient was a 30-year-old married white gv. 4, para 3 who saw her physician with this pregnancy in the second month. By menses she was due September 23, 1957, her L M P being December 16, 1956.

Month of Pregnancy

	1	2	3	4	5	6	7	8	9		
									1	2	3
Blood pressure		110/70	110/70	110/70		110/70	110/70	120/80	115/75	120/70	110/70
Weight		110	110¼	118		126	133	138	140	136	138
Urine		neg	neg	neg		neg	neg	neg	neg	neg	neg
Hb		10.0g				9.15g			11.2g		

She was Rh+ and the VDRL was non-reactive.

Her past medical, surgical and obstetrical history was non-contributory.

She had a total weight gain during this pregnancy of 28 pounds, but never had any edema, elevation in blood pressure, or proteinuria.

She was admitted to the hospital in possible early labor at 2:30 P.M., September 22, 1957. Examination revealed the cervix 1 finger dilated, the membranes ruptured (?) and the presenting part still high.

Labor Record

Date	Time	B.P.	Examination	Contractions	Rx
9-23-57	9:00 A.M.	114/68	Cx. thick 1F, pres. part high-membs. ruptured	q 8″	
″	2:00 P.M.			q 3″	
″	2:10 P.M.				50 mg. demerol
″	2:30 P.M.		cx. post. 85% effaced, 2½-3F dilated mid-station		
″	2:50 P.M.		(see below)	q 2-3″	

At 2:50 P.M. the nurses described what appeared to be a convulsion. The patient seemed unconscious, and both hands "were jerking." 1000 cc 5% G/W was started i.v. It was felt the patient had expired so an immediate postmortem section was done through a classical incision in the uterus and a living 6 pound, 8½ ounce male was delivered. The infant did well and was discharged from the hospital in good condition.

The patient's chest was also opened and cardiac massage attempted but the patient was pronounced dead at 3:10 P.M., 9-23-57.

An autopsy was done; the gross positive findings were cerebral edema and congestion, and chronic pulmonary congestion.

On microscopic sections no fetal scales or amniotic fluid could be demonstrated in the small capillaries of either the lungs or the brain that would have produced amniotic fluid embolism, and the exact mechanism of death was unexplained.

Comment:

The Committee thought this case was certainly unusual. If the death resulted from eclampsia as given on the death certificate it seemed as though there should have been some change demonstrated at autopsy. While it was felt this death must be considered a direct obstetrical one it was considered non-preventable and the saving of the infant was quite noteworthy.

An article in the American Journal of Obstetrics and Gynecology, 72:203:1956 stated that there were only 113 successful postmortem sections reported in the world literature. It is obvious that this doesn't represent all the infants that survived, for in Kentucky there were three postmortem sections with the fate of two infants stated for the year 1957. Both were born alive, one died neonatally the other, this case, seemed perfectly normal.

(Continued on Page 729)



. . . and one to grow on

A tiny tablet of REDISOL to stimulate the appetite — to help in the intake of food for growth.

REDISOL is crystalline vitamin B_{12}, an essential vitamin for growth and the fundamental metabolic processes.

Ideal for the growing child, the REDISOL tablet dissolves instantly on contact in the mouth, on food or in liquids.

Packaged in bottles hermetically sealed to keep the moisture out and to retain vitamin potency in 25 and 50 mcg. strengths, bottles of 36 and 100 — in 100 mcg. strength, bottles of 36, and in 250 mcg. strength, vials of 12.

Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

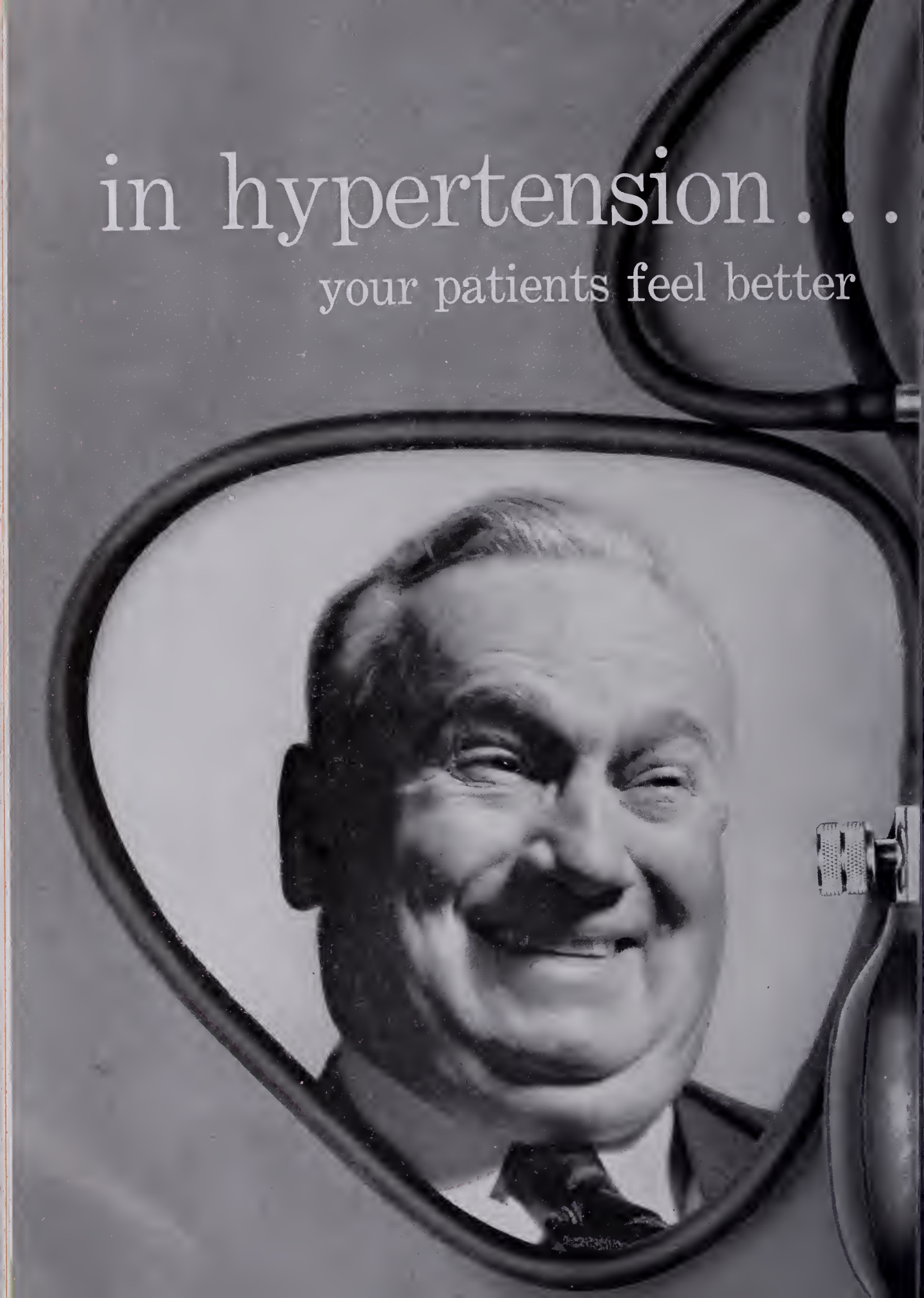
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cyanocobalamin, Crystalline Vitamin B_{12}

MSD

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REDISOL IS A TRADEMARK OF MERCK & CO., INC.


in hypertension . . .
your patients feel better

and
blood pressure
is controlled
safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

With RAUTENSIN and RAUVERA, two unique and dependable antihypertensive agents, patients feel better, have a brighter outlook and blood pressure is safely reduced.

in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.[1] The apprehensive hypertensive is calmed, yet side actions are " . . . either completely absent or so mild as to be inconsequential."[2]

RAUTENSIN®

each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys . . . no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.[3] Abrupt rise in blood pressure does not occur even when therapy is interrupted.[4] Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA®

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.; Dennis, E., and Ford, R.: Arch. Int. Med. *96*:530, 1955.
2. Terman, L. A.: Illinois M. J. *8*:67, 1957.
3. La Barbera, J. F: M. Rec. & Ann. *50*:242, 1956.
4. Bendig, A.: New York J. Med. *66*:2523, 1956.

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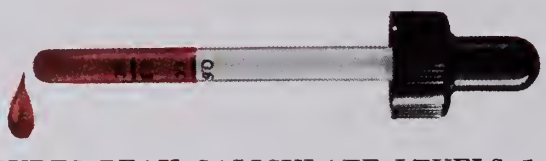
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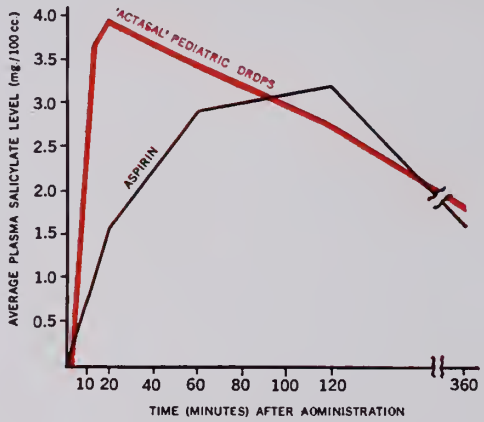
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BRAND OF CHOLINE SALICYLATE U.S. & FOREIGN PATENTS PENDING



ASSURES PEAK SALICYLATE LEVELS 5 TIMES FASTER THAN ASPIRIN[1,2,3]—WITH PROVEN BETTER GASTRIC TOLERANCE.



Comparative Plasma Salicylate Levels After Oral Administration of Doses of 'Actasal' Pediatric and Aspirin, Providing Equal Amounts of Salicylate.

Clinically proved – In thousands of cases by more than 180 investigators[4]

• more effective • better tolerated

A new and unique salicylate molecule in palatable solution.

DOSAGE: Each dropperful (0.6 ml.) contains 105 mg. Choline Salicylate, equivalent to approximately 1¼ grains aspirin.

Children 6-12 years: 2 to 4 dropperfuls every 3 to 4 hours, or as required. Children 3-6 years: 1 to 2 dropperfuls every 3 to 4 hours, or as required. Children under 3 years: 1 dropperful every 3 to 4 hours, or as required.

SUPPLY: 60 cc. bottle packaged with cellophane-wrapped calibrated dropper.

CITED REFERENCES: 1. Smith, P. K.: Personal Communication. 2. Wolf, J., Aboody, R.: Federation Proc. 18:605, 1959. 3. Broh-Kahn, R. H.: Federation Proc. 18:17, 1959. 4. Complete data available on request to the Medical Director.

ANTI-SEBORRHEIC FOR CRADLE CAP

SOROPON™

PEDIATRIC SOLUTION

CONTAINS CERAPON-C* 12.0% IN PROPYLENE GLYCOL WITH PARABENS 0.1% AND TYROTHRICIN 0.1%, PURDUE FREDERICK *BRAND OF TRIETHANOLAMINE POLYPEPTIDE COCOATE-CONDENSATE

Specifically prepared for safe, effective removal and prevention of cradle cap, by combining unique proteo-lipid sebulytic effect with anti-infective action.





Bialkin, G.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959.

CASE HISTORY: J. D., a 5 month old white male developed a dry seborrhea capitis at approximately 6 weeks after birth which covered the whole scalp. By the time of examination, the child had been treated with various detergent ointment and lotion preparations without apparent effect. 'Soropon' Pediatric Solution was applied as a shampoo, directly to the scalp to remove the encrustations. A lanolin ointment was applied to scalp because of inherent dryness. A series of 5 treatments was required for complete removal and after this treatment period the seborrheic eczema had virtually disappeared. The patient has been symptom free since then.

Bialkin, G.: A New Anti-Seborrheic Agent in Pediatric Practice. Arch. of Ped. (to be published).

SUPPLY: 'Soropon' Pediatric Solution is available in bottles of 4 oz.

The Purdue Frederick Company DEDICATED TO PHYSICIAN AND PATIENT SINCE 1892
NEW YORK 14, N.Y. | TORONTO 1, ONTARIO

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new for total management of itching,[1,2] inflamed,[3,4] infected[5,6] skin lesions



Dermatitis repens [with staph and monilia] 7 weeks duration



Cleared in 5 days

Mycolog ointment

Kenalog, Spectrocin and Mycostatin in Plastibase

antipruritic/anti-inflammatory/antibacterial/antifungal



Infectious eczematoid dermatitis of ankle—5 years duration



Cleared in 20 days

Mycolog Ointment—containing the new superior topical corticoid Kenalog—reduces inflammation,[3,4] relieves itching,[1,2] and combats or prevents bacterial, monilial and mixed infections.[5-7] It is extremely well tolerated, and assures a rapid, decisive clinical response for most infected dermatoses.

> "Thirty-one of 38 patients . . . obtained excellent or good control of dermatological lesions . . . [Mycolog] was highly effective, particularly in the management of mixed infections. Several recalcitrant eruptions which had not responded to previous therapy were remarkably responsive to the daily application of this preparation over periods of 2 to 3 weeks."[5]

For total management of itching, inflamed, infected skin lesions, Mycolog contains triamcinolone acetonide, an outstanding new topical corticoid for prompt, effective relief of itching, burning and inflammation[1-4]—neomycin and gramicidin for powerful antibacterial action[7]—and nystatin for treating or preventing Candida (Monilia) albicans infections.[8,9]

Application: Apply 2 to 3 times daily. Supply: 5 Gm. and 15 Gm. tubes. Each gram supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 100,000 units nystatin in PLASTIBASE.

References: 1. Shelmire, J.B., Jr.: Monographs on Therapy 3:164 (Nov.) 1958. • 2. Nix, T.E., Jr., and Derbes, V.J.: Monographs on Therapy 3:123 (Nov.) 1958. • 3. Robinson, R.C.V.: Bull. School of Med., U. Maryland 43:54 (July) 1958. • 4. Sternberg, T.H.; Newcomer, V.D., and Reisner, R.M.: Monographs on Therapy 3:115 (Nov.) 1958. • 5. Clark, R.F., and Hallett, J.J.: Monographs on Therapy, 3:153 (Nov.) 1958. • 6. Smith J.G., Jr.; Zawisza, R.J., and Blank, H.: Monographs on Therapy, 3:111 (Nov.) 1958. • 7. Monographs on Therapy, 3:137 (Nov.) 1958. • 8. Howell, C.M., Jr.: North Carolina M.J. 19:449 (Oct.) 1958. • 9. Bereston, E.S.: South. M.J. 50:547 (April) 1957.

And whatever the topical corticoid need, a suitable Squibb formulation is available—Kenalog-S Lotion—7½ cc. plastic squeeze bottles. Each cc. supplies 1.0 mg. (0.1%) triamcinolone acetonide, 2.5 mg. neomycin base and 0.25 mg. gramicidin. Kenalog Cream, 0.1%—5 Gm. and 15 Gm. tubes. Kenalog Lotion, 0.1%—15 cc. plastic squeeze bottles. Kenalog Ointment, 0.1%—5 Gm. and 15 Gm. tubes.

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in surgical and obstetrical procedures
where apprehension increases tension...
patients respond well to

VISTARIL®

hydroxyzine pamoate

EFFECTIVENESS AND SA[illegible] Vistaril establishes relaxed indifference to preoperative preparation without serious hypotensive effects.

PSYCHOTHERAPEUTIC POTENCY Vistaril makes possible the maintenance of an adequate degree of narcosis with reduced doses of narcotics.
Vistaril relieves tension and controls emesis in both postoperative and postpartum patients.

Recommended Oral Dosage: up to 400 mg. daily in divided doses.

Recommended Parenteral Dosage: 25-50 mg. (1-2 cc.) I.M., q. 4 h., p.r.n.

Vistaril is supplied in 25 mg., 50 mg., and 100 mg. capsules. The parenteral solution is available in 10-cc. vials and 2-cc. Steraject® cartridges; each cc. contains 25 mg. hydroxyzine (as the HCl).

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CLINICAL BRIEFS
FOR MODERN PRACTICE



How can the problem of "postcholecystectomy syndrome" be reduced?

A "routine" operative cholangiogram is now recommended in addition to thorough surgical exploration, reducing the number of cholecystectomized patients later presenting the same symptoms as before the operation.

Source: Vazquez, S. G.: J. Internat. Coll. Surgeons *28*:394, 1957.

for pre- and postoperative management of biliary tract disorders... **DECHOLIN®** *"therapeutic bile"*

*Hydro*choleresis with DECHOLIN combats bile stasis by flushing the biliary tract with dilute, natural bile...

- corrects excessive bile concentration
- helps to thin gallbladder contents
- benefits patients with chronic cholecystitis, noncalculous cholangitis, and biliary dyskinesia

in functional G.I. distress... **DECHOLIN®** with **BELLADONNA**

- reliable spasmolysis
- improved liver function

available: DECHOLIN Tablets: (dehydrocholic acid, AMES) 3¾ gr. (250 mg.). Bottles of 100, 500 and 1,000; drums of 5,000.

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For every topical indication, a Burroughs Wellcome 'SPORIN'...



OINTMENT: Tubes of ⅛ oz. and ½ oz. (with applicator tip) for ophthalmic or dermatologic application.

OTIC DROPS: Bottles of 5 cc. with sterile dropper.



OINTMENT: Tubes of ½ and 1 oz. and tubes of ⅛ oz. with ophthalmic tip.

OPHTHALMIC SOLUTION: Bottles of 10 cc. with sterile dropper.

NEW { **LOTION:** Plastic squeeze bottles of 20 cc.
POWDER: Shaker-top bottles of 10 Gm.



OINTMENT: Tubes of ½ oz., 1 oz. and ⅛ oz. (ophthalmic tip).

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"Itch completely gone -- dramatic relief!"

Chronic bronchial asthma (male, 62)

"This patient, on his own and his wife's admission, is better, has had more relief than he has had in 35 years..."

Polyarteritis nodosa (suspected) (male, 19)
"Equivalent to prednisone. Seemed to have less acne on Deronil."

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"After 4 tablets stat, required no further treatment. Good results, sense of well-being."

Intractable asthma (cor pulmonale) (male, 68)
"Marked diminution of symptoms since onset of therapy." (Dosage: one tablet t.i.d.)

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FROM DOCTORS WRITING TO SCHERING*

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DERONIL—T.M.—brand of dexamethasone.

Supplied—0.75 mg. tablets.

Herpes Zoster (female, 55)

"Results are outstanding.... Pain decreased after first three doses. Zoster dried in 4 days." (Dosage: one tablet t.i.d.)

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"Full relief, resumption of work." (Dosage: one tablet t.i.d. to one tablet daily)

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BLOOMFIELD, N. J.

Exfoliative dermatitis (male, 84)
"Marvelous results - skin completely cleared except over ankles where there is [illegible]"



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Darvon Compound combines in a single Pulvule® the analgesic action of Darvon with the antipyretic and anti-inflammatory benefits of A.S.A.® Compound (acetylsalicylic acid and acetophenetidin compound, Lilly). When inflammation is present, Darvon Compound reduces discomfort to a greater extent than does either analgesic given alone.

Usual dosage: 1 or 2 Pulvules three or four times daily.

Also available: Darvon, in 32 and 65-mg. Pulvules.

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The JOURNAL of the
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VOL. 57 · JUNE, 1959 NO. 6

Coarctation Of The Aorta*

CARLOS A. FISH, M.D.**

Louisville, Ky.

WHILE not a common cause of hypertension in the postpubertal period of life, coarctation of the aorta is important to the practicing physician, for it is a defect which can be remedied by modern surgical methods with a high degree of safety. It should be recognized by the clinician without recourse to diagnostic techniques requiring highly specialized skill and equipment. This discourse seeks only to review basic features of the condition and presents a brief case history to emphasize the importance of utilizing a high index of suspicion and simple diagnostic measures to arrive at a diagnosis.

Basic Considerations

Coarctation of the aorta of the adult type consists of a localized constriction of the aorta just proximal to the point of entrance of the ductus arteriosus. The aorta is usually dilated proximal to the constriction. The ductus arteriosus undergoes normal obliteration. There are no arteriovenous shunts. The basic defect consists of a rather high degree of obstruction of the blood flow to the descending aorta at the point of constriction, resulting in the blood reaching the lower extremities mainly through collateral channels. These are chiefly from the subclavian arteries through the intercostal arteries to the descending aorta and by way of the internal mammary arteries through the superior and inferior epigastric arteries to the femoral arteries. Since the posterior intercostal arteries constitute the principal collateral pathways, they become enormously dilated and tortuous, and in the course of 12 to 14 years their pulsation erodes the ribs and produces a scalloping of the lower margins of the ribs, which results in a diagnostic roentgen appearance. The collateral circulation increases as the patient grows. Over a period of years it becomes progressively more conspicuous. For this reason, the complete clinical picture, one of the few examples of congenital heart disease which can be recognized with almost complete certainty at the bedside, does not become clearly manifest until early adult life. For poorly understood reasons the condition occurs about six times as frequently in males as in females, and is characteristically associated with precocious physical development in the males, whereas in women it is often associated with ovarian agenesis.

Clinical Findings

The condition should be suspected in anyone with hypertension, especially if the patient is in the younger age group. By far the most important diagnostic sign is an elevated blood pressure and increased pulsation in the upper extremities associated with diminished or absent pulsation and a lower systolic blood pressure in the lower extremities. The pulse in the temporal arteries and in the upper extremities is full and bounding in marked contrast to the weak pulsation in the femoral arteries and the posterior tibial and dorsalis pedis arteries due to the circuitous pathways through the collateral circulation the blood must take to reach the lower extremities. The hypertension in the upper extremities may often be extreme, but

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this is not necessarily so, especially in the younger age groups. At least part of the explanation for the hypertension may be on the basis of chronic renal ischemia resulting from the impaired blood flow through the circuitous channels to the kidneys.

The symptoms of coarctation of the aorta are not prominent. They result from hypertension in the upper one third of the body and poor circulation in the lower two thirds of the body. Headache, throbbing of the head, and flushing of the face are occasional manifestations. Coldness and weakness of the lower extremities and occasionally, intermittent claudication may be the presenting symptoms. Difficulty in the healing of wounds in the lower extremities may occur. The majority of patients, however, have no complaints, and the diagnosis is first suspected on the basis of hypertension being discovered in the upper extremities when the patient is being examined for some unrelated condition.

The size of the heart is usually within normal limits although the left ventricular musculature is hypertrophied to some degree by the increased resistance in the constricted area of the aorta. If the hypertension is severe, A_2 may be accentuated. There may or may not be a short systolic murmur over the aortic area. Dilatation of the ascending aorta may produce conspicuous pulsation in the suprasternal notch. The occurrence of murmurs in unusual locations such as in the interscapular region or over both internal mammary arteries is a helpful diagnostic sign.

X-ray evidence consists in changes relative to the aorta and not the heart itself. In some instances dilatation of the ascending aorta associated with an inconspicuous descending aorta may be found. By far the most important x-ray finding, however, is notching of the ribs, which is usually not present before the age of 12 to 14. X-ray examination after the injection of 70% Diodrast may demonstrate the area of constriction in the aorta, but usually the diagnosis can be made by simpler means. Cardiac catheterization may be necessary if the diagnosis is in doubt or complicating anomalies are suspected.

Complications

Complications result from the hypertension in the head and upper extremities mainly. Cerebral accidents are common. Rupture of the aorta is an important cause of death. In one series of autopsy studies, death was due to congestive failure in 75% of the cases studied. Acute and subacute bacterial endocarditis is another risk. The condition is not necessarily incompatible with a long and active life, however. The oldest reported patient with coarctation of the aorta was a man 92 years of age.

Treatment

Definitive treatment consists of surgical correction of the defect. The operation consists of excision of the constricted portion of the aorta and an end-to-end anastomosis between the proximal and distal ends of the aorta. When this is not feasible, the area may be by-passed by anastomosis of the carotid or left subclavian artery to the descending aorta. Medical treatment consists in treatment of the complications and prophylaxis against subacute bacterial endocarditis, and avoidance of sudden physical strain which could cause rupture of the aorta or a cerebral accident. The over-all prognosis is good and the decision to operate must, of course, be individualized.

A Case History

A case history is presented to illustrate the importance of clinical findings as well as of highly specialized techniques. Mrs. W. G., age 28, was referred for examination because of hypertension which had not responded to medication and three months bed rest. The patient was first informed that she had hypertension at the time of a routine premarital examination at the age of 16. Hypertension was noted at the time of every subsequent examination. The patient was not aware of the details of the findings nor of her treatment. Her subjective complaints consisted only of vague weakness, dyspnea on exertion such as climbing one flight of steps, and of palpitation on slight physical exertion. Pertinent physical findings were a blood pressure of 200/130 in each arm, and 0/0 in each leg. No pulsation could be felt in the abdominal aorta or distally. A soft systolic grade one murmur was audible in the aortic area. X-ray and fluoroscopic examination of the chest revealed no findings to support the clinical diagnosis of coarctation of the aorta. The patient was therefore referred to Dr. Leonard Leight for special studies.

Cardiac catheterization, including the use of dye dilution curves, demonstrated that there was no other congenital lesion. Angiocardiography was done and demonstrated beautifully a localized area of constriction just distal to the origin of the left subclavian artery. The patient was operated on by Drs. Ransdell and Kleinert on February 12th, 1958, and the presence of a localized coarctation in the previously mentioned location was confirmed. The area of coarctation was sufficiently short to allow a direct anastomosis of the aorta after excision of the constriction. The patient had an uneventful postoperative course. Pulsation has been normal in the femoral arteries and distally since the operation, and blood pressure in the arms and legs has remained essentially equal. The patient has remained asymptomatic.

Summary and Conclusions

1. The possibility of coarctation of the aorta should be considered in all hypertensive patients, especially those in the younger age groups.

2. The combination of hypertension in the upper extremities and hypotension and poor arterial pulsation in the lower extremities, together with evidence of collateral circulation, is highly diagnostic.

3. When clinical evidence is inconclusive but suggestive, angiocardiography and cardiac catheterization are indicated.

4. The condition is amenable to surgical cure.

5. An illustrative case history is presented.

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Maternal Mortality Study; A Medium of Education*

ANTHONY RUPPERSBERG, JR., M.D.

Columbus, Ohio

AS we gently pause and look back 40 years, we survey with satisfaction the enviable record established in Obstetrics in this country. Lest we lull ourselves into a false sense of security it is well occasionally to review cardinal facts which promoted the gradual improvements we accept as commonplace today. It is desired to stress particularly the part played by education in this program which improved maternal health, and reduced maternal mortality.

Summaries of vital statistics indicate a gross decline in the maternal death rate of the United States from 61 per 10,000 live births in 1915 to 4.3 per 10,000 live births in 1957,[1] (Figure 1). This represents a drop of 93% over a period of 42 years, allowing for statistical adjustments to compensate for changes in reporting from birth registration states, and introduction of the 5th revision of the International List of Diseases in 1949.

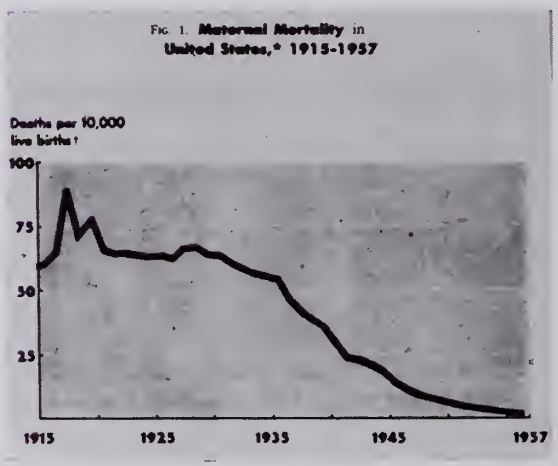


FIG. 1. **Maternal Mortality in United States,* 1915-1957**

**Health Information Foundation*

**Birth Registration States only, 1915-32. In 1915 these consisted of 10 states and the District of Columbia.*

†*Rates since 1949 are adjusted to the Fifth Revision of the International List of Diseases and Causes of Death.*

Source: Various reports by the Office of Vital Statistics.

Many factors are responsible for this heroic reduction in maternal deaths:

1. Improvement in hospital standards, relative to sanitation and sepsis.
2. Extensive research proved the potentials and dynamics of normal pregnancy and its complications.
3. Prenatal care was introduced and advocated.
4. Physicians attended progressively more deliveries.
5. Nutrition research provided better diets.
6. Improvements in obstetrical surgery and anesthesia.
7. Postgraduate courses and resident training programs began.
8. Antibiotics and whole blood became available for required use.

History

It seems easier to appreciate the dramatic changes in maternal death rates if we examine figures available for several centuries. However, it must be remembered that statistical rates and trends were not uniform until the 20th century. Early sporadic reports were available occasionally, but under rather incomparable circumstances.

The following items are highlights in the history of maternal death rates and their investigation:

1664 —Epidemic, Hotel Dieu Hospital, Paris.[2] 33% of parturient women died.
1676 —Willis, wrote "Febis Puerperarum,"[3] first formal treatise published on maternal mortality.
1660-1680—London, England. 1/44 died.[4]
1775 —John P. Frank (Bruchsal). Rate of 1/85 fell to 1/125.[5]
1786 —Hotel Dieu Hospital, Paris. 1/15 died.[4]
1841 —England and Wales. 1/170 died.[4]

*Presented before the Louisville Obstetrical and Gynecological Society, Louisville, Kentucky, 26 January, 1959.

1843 —Oliver Wendell Holmes' paper.[3] Later quoted 1/100 died in 1860 in U.S.A.
1851 —England and Wales. 1/192 died.[4]
1859 —Semmelweis' paper published. Maternal mortality 1/10 reduced to 1/100 through use of chlorine water[3] to wash examining hands.
1875-1881—Massachusetts, (Middlesex, East Distr.)[6] 1/140 died in 2666 labors reported (2709 babies born).
1881 —England and Wales. 1/263 died.[4]
1915 —U. S. A. 1/165 died.[7]
1921 —Howard (N. Y.). 1/406 pregnant women died.
1915-1919—7.28 per 1000 live births (1/138).[7]
1920-1924—6.89 per 1000 live births
1930-1934—6.36 per 1000 live births
1940-1944—2.81 per 1000 live births
1950 — .83 per 1000 live births (1/1204).[7]
1955 — .47 per 1000 live births

Maternal Health Team

Today we have changed a few concepts relative to maternal deaths. It is conceded that a scientific study of etiology is rewarded by facts which can be employed to reduce preventable mortality among similar cases in the future. However, in Ohio we have come to employ these features from our maternal mortality studies to *improve maternal health*. Thus critical items which evolve from such a study not only prevent the pregnant woman from becoming a casualty, but also promote improvement in her health that she may live long to enjoy her family.

These factors have been augmented and organized into a gigantic project which we call The Maternal Health Program. As shown in Figure 2, it requires a well organized team of *eleven* members to operate the huge plan:



Fig. 2 Team for the Maternal Health Program

1. The expectant mother, "center" of the team.
2. The Lay Public.
3. The Medical Student.
4. The Externe.
5. The Interne.
6. The Resident Physician.
7. The Physician.
8. The Health Department Member.
9. The Nurse.
10. The Medical Record Librarian.
11. The Social Worker.

The "coach" is the Committee on Maternal Health! The primary obstacles are hemorrhage (H), infection (I) and toxemia (T); secondary obstacles (other causes of death) are not shown here.

Training The Team

Long hours of research and rehearsal are required to prepare this vast team for a well coordinated operation. Just as in the case of the athletic team, orientation and training of "team members" are necessary.

Source of material. The wealth of material required to educate and train "The Team" should be available from data and experiences of "The Coach" (Committee on Maternal Health). If the Committee is young in experience, statistics, data and experiences of other Maternal Mortality Studies may be used. A program of indoctrination must be planned.

Material. To properly train the team, the training program should include information on at least the following subjects which pertain to maternal deaths and their study. This material should be properly arranged so that it will be of maximum interest to each member of the team, at his own respective level of reception.

1. Primary and secondary causes of maternal deaths in the community, maintaining anonymity.
2. Data on both common and rare diagnoses.
3. *When* death occurred; antepartum (died undelivered), intrapartum, postpartum (and postabortal).
4. Data on "non-maternal" cases.
5. Quality of records of the physicians and hospitals (important).
6. Avoidability of maternal deaths. Evaluate *factors* in preventability and responsibility in the ideal academic sense.
   a. Factors:
      (1) Patient factors (P_1) to include the facilities she denied herself, her failure

to obtain care, and her failure to follow orders.

(2) Personnel factors (P_2).

(a) Physician. Diagnosis, judgment, management and technique. Failure to recognize complications; poor timing of intervention; failure to use accepted methods, or to request consultation promptly.

(b) Hospital. Lack of available facilities: equipment, x-ray, blood bank or proper anesthesia.

(c) Hospital personnel. Absence or errors of aides, orderlies, etc.

(d) Family, or the Public. Errors or negligence in advice of patient, or patient's physician concerning her condition.

Application

Once the material for the educational program has been secured and properly arranged, it must be integrated into the training schedule, so as to reach each team member at the proper level. It may be applied individually, or to groups, as in the case of the lay public.

1. Expectant Mother. Instruction usually begins with the physician during the first visit. Here the doctor has an excellent opportunity to instill confidence in the patient. Literature containing precise instructions and educational material may be given to the patient. Prenatal counselling classes for the patient and her husband gracefully prepare her for the onset of labor. Adequate prenatal care with a sufficient number of visits assures the physician of the patient's physical condition and inspires her confidence in herself and the doctor.

2. Lay Public. The patient, inspired by her physician and his literature, will transmit the prenatal information to her family. The general public is apprised of the intent, scope and results of The Maternal Health Program through news items, lectures, radio programs and various exhibits, prepared by members of the medical profession.

3. Medical Student. In addition to conferences, lectures and demonstrations concerning normal and abnormal obstetrics, the course in obstetrics includes data from maternal death studies to indicate impending catastrophies. Advice concerning consultations and minimum standards for obstetrical care is included. Clinical work emphasizes "danger signals" of complications and prescribes prompt management. During hospital rounds and conferences maternal morbidity is discussed. All maternal deaths are presented in detail and responsibility factors are evaluated.

4. Externe (clerkship). Orientation and instruction commensurate with the duties of the externe in the Department of Obstetrics and Gynecology are given from the beginning of his service. Clinics, in-patient rounds, conferences, and autopsies provide the externe with excellent instruction. He is continuously trained in the essential elements of good antepartum, intrapartum and postpartum care. Not only is the externe trained to keep full and accurate hospital records, but he is also trained to prepare and present case reports before various staff groups; these case reports follow a pattern of protocols published in maternal death studies.

5. Interne. The program of interne training usually includes much the same as the material listed for the externe, except that the interne performs clinical work under supervision of the attending physician or resident. Journal clubs develop instruction in maternal health. Frequent discussion of morbidity and maternal deaths augments the program of education.

6. Resident. The training of the resident physician includes much the same material except on an advanced level. Soon the resident becomes an instructor for internes and externes, as well as medical students in the teaching institution.

7. Physician. Education and training for the physician is available through various conferences, refresher courses and postgraduate work. He is reminded of the necessity for keeping accurate records; the physician should endeavor to place the correct diagnosis on the death certificate.[8] Training guides him to search for the correct diagnosis of complications and to seek consultation early. "Minimum Standards for Obstetrical Care" provide an excellent check list for patient management. He encourages relatives to permit autopsies and he transmits details of the patient's death to the Maternal Mortality Committee. He assists in training the house staff of the hospital, and he may also participate in the instruction of student nurses. If the physician specializes in Obstetrics and Gynecology he becomes a key figure in the

educational program of the institution, utilizing all of the available "teaching material."

8. Health Department Members.[9] After a complete orientation, members are trained to educate patients and the public in the Maternal Health Program. In cooperation with the local medical profession, dental and obstetrical clinics may be established. They may also assist in establishing blood banks. Antenatal and postnatal house calls may be made to assist obstetrical patients; "danger signals" are recognized early and reported to the patient's physician. In the vital statistics bureau birth and death certificates are checked to assist the local Maternal Mortality Committee in the discovery of maternal death cases.

9. Nurse. The role of the nurse[10] in the Maternal Health Program is equally important. As the confidante of the female patient she becomes a respected advisor. She cautiously observes the patient for "danger signals," reporting them promptly to the physician. Armed with information on maternal deaths and their prevention, the nurse becomes a potent force in the education of the Lay Public. When she administers an anesthesia her responsibility is not diminished; in the event of a preventable death of the patient she may share "personnel responsibility."

10. Medical Record Librarian.[11] This member of the team is often forgotten in her routine work. Well informed on the maternal mortality project she may be of great assistance to the Committee seeking information from records. Primarily she is the initial "guardian" to insure the completeness of hospital records. Alert to the circumstances which classify a case as a "maternal death" she may often discover the case which has been overlooked. This situation may arise through the readmission of a critically ill woman who delivered or aborted in the last six weeks, six months, or year. By reporting the incident she serves as an indispensible assistant. The same holds true when an infant is admitted or readmitted, after the mother's death at home.

11. Social Worker. The intelligent worker is trained to inspire confidence in all patients. Properly informed concerning the Maternal Health Program, her counselling coordinates efforts of the physician and the nurse to encourage the patient to follow prenatal instructions, report danger signals at once and to return for prescribed visits. As the social worker helps the pregnant patient solve economic and social problems in her family, stress, tension and anxiety are alleviated in the mind of the patient.

It is assumed that the Committee on Maternal Health ("The Coach") has been fully trained and is apprised of the major problems which will confront the operation of the program. Initially, the Committee must provide an operating plan for the project to include workable terminology, policies, a simple but adequate questionnaire form for data and an educational program for "The Team," utilizing data from the Maternal Mortality Study. The security of the program's future depends upon sound and careful initial planning.

Medium of Further Education

In order that the vast possibilities of expanding the educational phases of the program may be appreciated, we would like to present briefly the operation of two studies in Ohio. The first, often called the "Mother Study," was the Franklin County Maternal Mortality Study. This project studied *all* deaths in women who died in the *county* (at home or in hospital) from causes related directly or indirectly to pregnancy, labor or the puerperium (up to 365 days after termination of any stage of gestation). The Study is now operating in its 12th consecutive year.

The second project is the Ohio State Maternal Mortality Study, often called the "Daughter Study" because the meticulous planning employed for the Franklin County Study was used as a pattern to organize the Ohio State Study (1953); the Franklin County Pelvic Cancer Delay Study (1954); and the Franklin County Perinatal Mortality Study (1956).

In 1947 Drs. Richard L. Meiling and Anthony Ruppersberg, Jr., undertook a careful preliminary study of "puerperal deaths" occurring in Columbus, Ohio. Figures from the local bureau of vital statistics revealed a "puerperal death rate" somewhat higher than communities of similar size. It was noted that in 1935 the rate was 9.1 per 1,000 live births! Since deaths from abortions and ectopic pregnancy were not included, the height of the figure was even more shocking. Nor were deaths in Franklin

County (outside Columbus) included! It was obvious that by studying details surrounding each maternal death, a wealth of educational material could be obtained to aid in the prevention of similar deaths in the future. Hence, the two physicians became a two-man Committee and set about organizing a systematic study of maternal deaths occurring in Franklin County, including Columbus, Ohio.

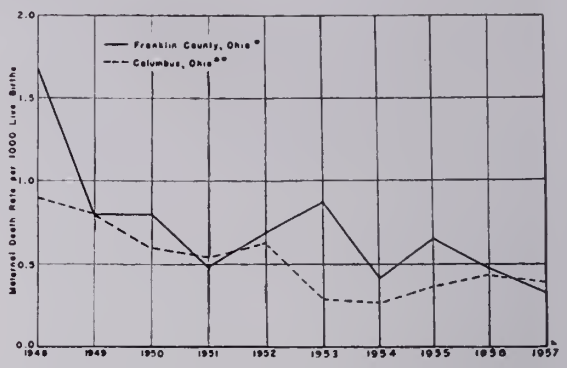
After months of careful planning, the study officially commenced on 1 January 1948. At first every case was investigated under great opposition. But every source of information was explored, from physician to hospital. The medical public was reluctant to accept policies of anonymity and education at first; but finally the sincerity of purpose of the two-man Committee gradually penetrated general resistance.

Realizing that a sponsor would be necessary for the project if it were to survive in the future, the founders formally presented the program to fellow members of The Columbus Obstetric-Gynecologic Society, on 27 October 1948. The Society accepted moral and financial sponsorship of the study by unanimous vote and appointed a committee, including the founders, to carry forth the project.

The educational phase of the study began with the publication of a report on the project after its first year of operation, 1948.[12] Findings and data published anonymously were available to all physicians in the county. The maternal mortality rate for this first year was 1.6 per 1,000 live births. Reports were published every succeeding year.

After five years of operation, a voluminous report of the project was published in 1954.[13] Material and experiences obtained in connection with the study were placed on slides and the authors spoke before various medical groups. An exhibit portraying statistics from the study, was prepared and was shown at county and state medical meetings, the A.A.O.G. Meeting in Chicago and also the A.M.A. Meeting in Atlantic City.

The Franklin County Maternal Mortality Study now in its 12th year has accumulated a wealth of statistical material, all concerning Franklin County, including Columbus. Occasionally articles concerning the study were published in the local lay press. Whereas the maternal mortality rate was 1.6 per thousand live births in 1948, it was reduced to 0.35 per thousand live births in 1957 (Figure 3).



Based on maternal deaths, included in Franklin County Maternal Mortality Study of deaths which occurred in Franklin County.

**Based on maternal deaths, resident of Columbus, and recorded by Columbus (Ohio) Health Department.*

Fig. 3. Maternal deaths per thousand live births, Franklin County (from study) and Columbus, Ohio, 10 years, 1948-1957 (Incl.).

Ohio State Study

The Ohio State Maternal Mortality Study officially began on 1 January 1955. For two years previous to this, many, many hours were spent in cautious step-by-step planning for the ambitious project to cover 88 counties.[14] The Ohio State Medical Association, by action on the floor of its House of Delegates, accepted sponsorship of the program to reach and represent its 9,000 physicians.

In general, principles and planning for the Franklin County Study were utilized for the State Study, superimposing the county plan over each county area (county medical society) in Ohio. Policies and nomenclature, proven in Franklin County, were accepted for the Ohio Study, by the Committee on Maternal Health.[14] An improved questionnaire form was developed; the Franklin County Study accepted this improved form and employs it for the sake of uniformity.

The Committee on Maternal Health, Ohio State Medical Association, has several functions, most important of which is an education and training program for Ohio physicians. Material obtained in the Maternal Mortality Study is evaluated and classified into categories,

after the Committee has studied every case.

1. Case reports are published anonymously with educational comments in the "Maternal Health in Ohio" column of the *Ohio State Medical Journal,* each month.

2. In the same column, an *annual* report is published showing a complete analysis of cases for the year. So far the initial report for 1955 has appeared.[15]

3. The Committee supports and assists in maintaining a training program in obstetrical anesthesia, operated for Ohio physicians by the Ohio Society of Anesthesiologists.

4. "Guiding Principles for Obstetric Care," a set of "minimum standards," was prepared and published by the Committee, after three years of work and deliberation.[16]

5. Educational data from the Maternal Mortality Study have been compiled in packets, in outline form. These packets containing visual aids, are available for use in various county medical society meetings throughout the State.

6. The Committee is preparing an exhibit on Maternal Health to be demonstrated at the State Meeting. Aid is also given county medical societies in the preparation of exhibits and educational material pertaining to Maternal Health.

Results

From the State Study for the year 1955 there were 96 maternal deaths among 222,689 live births reported in Ohio. The maternal mortality was 0.431 per 1,000 live births (or 4.31 per 10,000 live births).

Analyzing these deaths,[15] among other interesting features it was discovered that under primary causes of death, hemorrhage led with 15 deaths (see Figure 4). In order, the next single cause (among "other causes") was anesthesia, which accounted for 14 deaths. This fact has led to intensive further investigation into the circumstances surrounding maternal deaths from anesthesia. The surface of this abundant educational medium has merely been scratched.

Conclusion

1. The background and operation of two Maternal Mortality Studies in Ohio have been presented; educational phases of their programs are emphasized.

2. Results realized today, and further results desirable in the future, are obtained only after meticulous planning in a Program of Maternal Health.

3. A TEAM of individuals is required to execute a complete program.

4. Through its wealth of material and information, the Maternal Mortality Study provides an excellent medium for the education of many people, from the expectant mother to members of the Committee.

5. A thoroughly organized program provides for the transmission of this information to innumerable persons.

6. The pattern of planning for the Maternal Mortality Study may be used to plan other studies in a given community.

Ohio Maternal Mortality Study for 1955

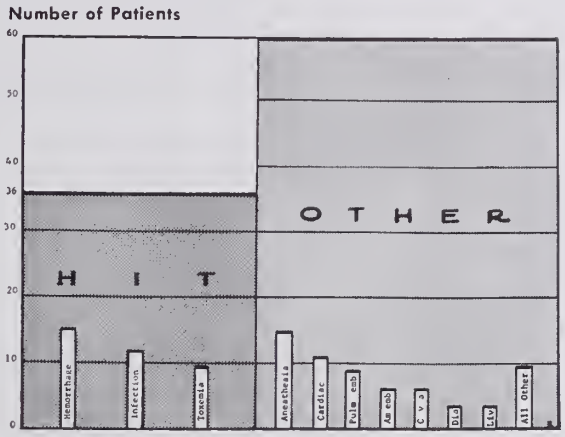


Fig. 4 Classification of primary causes of death; 96 maternal deaths, 1955.

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The Early Detection of Uterine Cancer By The Papanicolaou Smear*

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THIS paper has two principle objectives. The greater of these is to inform physicians, especially those engaged in General Practice, of the value of the uterine cancer smear, of the necessity of collecting a smear on every adult woman and of the ease and simplicity of collecting a smear in a busy office practice. The remaining purpose of this paper is to report my personal experiences with the Papanicolaou smear in my private practice.

General Discussion

Although 120 years have elapsed since the study of a smear examination on body fluid was first reported (Donné, 1838), the value of exfoliative cytology in the early diagnosis of malignancy was not fully appreciated until 1943 with the publication of Papanicolaou and Trout's Monograph on this subject. Since that time this concept has been accepted universally with a degree of unanimity and enthusiasm seldom matched in the long annals of medical history. The reason for this widespread acceptance and use is that uterine cancer can be detected earlier by this method than by any other presently known.

The literature on this subject has become voluminous. By the end of 1952 over 1,200 papers had been published relative to cytology, the overwhelming majority of which dealt with uterine exfoliative cytology. About this same time, or perhaps a little later, over 2,500 cases of carcinoma in situ had been reported. A representative bibliography is attached for those who may wish to pursue this subject. Knowledge accrued through investigative work in this new field has created problems and raised questions that may challenge some very basic medical concepts.

For example, is carcinoma in situ really cancer? Will carcinoma in situ always progress to invasive cancer? Does all invasive cancer begin as carcinoma in situ? What do we know of the life history of carcinoma? Finally, is the cervical-vaginal smear a reliable method of screening for uterine cancer?

While the final answer to most of these questions is not yet known, much has been learned. Most authorities today believe that carcinoma in situ is truly cancer that has been detected early in its life history and prior to invasion. Ruben first expressed this belief in 1910 and Schiller and others also believed this. However, these views were not generally accepted then and are not universally accepted now, for inherent in the definition of carcinoma have been two basic concepts: (a) invasion, and (b) destruction of the host if the carcinoma is not eradicated or arrested. Now a new concept appears: that cancer may exist for years without invasion or destruction of the host. Apparently, in the light of our present knowledge, carcinoma in situ does not always progress to invasive carcinoma but will do so in the majority of cases.

Much controversy and uncertainty exists today in this new and fascinating field of exfoliative cytology. On one point, however, there is little or no doubt, namely, the reliability of the Papanicolaou smear in screening for uterine cancer. This method is more reliable in the detection of cervical cancer than endometrial cancer. With the former, better than 90% accuracy has been consistently reported, while in the case of detection of endometrial cancer 70% to 80% accuracy has been obtained. It is apparent, then, that we have a method at our disposal whereby uterine cancer as a cause of death can almost be eliminated.

Each year 25,000 to 30,000 women die from uterine cancer. It follows that every adult woman should have periodic, usually annual, cervical smears and that the taking of these smears should be an integral part of the physi-

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cal examination of every adult woman. To accomplish this requires education of both physicians and the public.

Personal Experiences

The second part of this paper concerns itself with a preliminary report of my personal experiences with the Papanicolaou smear in private practice. Laboratory facilities for the processing and reporting of cervical smears in volume first became available in Louisville in the summer of 1956. This report covers the period from that time through December 31, 1957. During this time all non-pregnant women in my practice age 21 or over were subjected to a cervical smear. Actually, two smears are taken on each patient: one smear is made from material aspirated from the cervical canal and the second smear from cells scraped from the squamous-columnar junction. This is extremely important as most cervical cancer arises from this area. An Ayre spatula or ordinary tongue blade is used to obtain this material. These smears are immediately placed in a fixative of equal parts of ether and alcohol and sent to the laboratory. The total time required to obtain these two smears is less than one minute.

As stated above this preliminary survey included no pregnant women. A great deal of controversy exists among cytologists as to whether pregnancy alters cervical cytology significantly. Therefore, since this was our first clinical study, it was decided to exclude these patients.

Results

A total of 1,237 patients were studied in the eighteen-months period ending December 31, 1957. The results were as follows:

Group 1. Negative	903
Group 2. Hyperkeratosis Trichomonas Atypical cells—Negative Metaplasia—Negative	234
Group 3. Atypicality— Repeat smear recommended	37
Group 4. Atypical cells— Biopsy recommended	23
Group 5. Suspicious— Cone recommended	18
Group 6. Positive smears— Cone recommended	22
TOTAL	1,237

In the follow-up smears and biopsies in those patients comprising Groups 3 and 4 above, no positives were found, although five were lost to follow-up.

In Group 5 where the original smear report was *SUSPICIOUS, RECOMMEND CONE,* 16 of the 18 patients were hospitalized and cold or sharp knife conization of the cervix and D & C was done. Fourteen of these were negative for carcinoma of the cervix and 2 were reported carcinoma in situ of the cervix. Of the remaining two patients in this Group, one had a repeat smear which was reported as negative and one was lost to follow-up.

In Group 6 where the original smear report was *POSITIVE, RECOMMEND CONE,* all were hospitalized and cold or sharp knife conization of the cervix and D & C was done. Two of these 22 cones were reported as *DYSPLASIA*—i.e., no malignancy was found. The remaining 20 cones were all reported as *POSITIVE:* 19 carcinoma in situ of the cervix and 1 invasive carcinoma of the cervix.

Thus, of the 1,237 patients studied, one was found to have invasive cancer and 21 were found to have pre-invasive cancer (carcinoma in situ). The average age of these 22 patients was 35½ years. Five patients were under 30 years of age, the youngest being 26 years old. The oldest patient in this group was 46 years of age.

Summary

1. Uterine cancer can be detected earlier by the cervical (Papanicolaou) smear than by any other method presently known.

2. Approximately 25,000 women die each year from uterine cancer.

3. The incorporation of the Papanicolaou smear as an integral part of the examination of every adult women is stressed. The need of this is obvious.

4. The time required to obtain such smears is less than one minute per patient.

5. The cervical smear is a screening device and does not constitute a diagnosis. All abnormal smears must be confirmed by appropriate tissue study.

6. A preliminary study of my experience with the uterine smear in private practice is reported.

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Infectious Mononucleosis: Diagnosis And Treatment*

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INFECTIOUS mononucleosis is an acute, self-limited disease of unknown etiology with varied clinical manifestations, a relative or absolute lymphocytosis with abnormal lymphocytes, and a high concentration in the blood of heterophile antibodies against sheep erythrocytes. Emil Pfeiffer described such a disease in 1889 and called it "glandular fever."[1] Sprunt and Evans described the abnormal cells peculiar to this disease in 1920, and Paul and Bunnell discovered the associated antibodies against sheep cells in 1932.[2]

I shall discuss the diagnosis and treatment of this disease and give a brief analysis of 16 cases seen at the Lexington Clinic in the past two years. Peripheral blood smears were stained by the Wright modification of the Romanowsky method. The Davidsohn modification of the Paul-Bunnell test was used to determine the presence of the heterophile antibody of infectious mononucleosis.

Diagnosis

Criteria for diagnosis may be grouped as follows: the clinical characteristics, the hematologic findings, and the serologic findings. The majority of cases meet all criteria, if followed through the entire course of the disease. Some cases, however, meet only one or two of the criteria, possibly because of the particular stage of disease studied.

Clinical Characteristics

Typically, there is fever, posterior cervical lymph node enlargement, and acute pharyngitis. The disease usually occurs in the second and third decades, although it has been reported to affect persons from two months of age to sixty-five years. Fever is present in almost all cases. By the end of the first week, according to one report, acute pharyngitis is present in 75 per cent of cases,[1] and usually there is a thick white exudate over the tonsils. In other cases described as "typhoidal," there is fever, headache, and sometimes rash. Palatal petechiae or multiple pinpoint lesions on the soft palate near the junction of the hard palate have been described as a useful early sign of infectious mononucleosis.[3] Posterior cervical lymph node enlargement is characteristic. The presence of a palpable spleen is reported to occur in as many as 50 per cent of cases. Jaundice occurs in rare instances. Unusual "protean" manifestations include pericarditis, myocarditis, thrombocytopenia, hemolytic anemia, and central nervous system involvement such as meningitis, encephalitis, and the Guillain-Barre syndrome.[4] A rare complication is rupture of the spleen.[5] This should be suspected when there is severe abdominal pain, pain in the left side of the chest and left shoulder, and when there are signs of hemorrhage. The duration of the disease varies from two weeks to two months or more. Recurrence is rare.

Hematologic Findings

An increase in abnormal lymphocytes (total of 50 per cent or more) can almost always be detected at some time from the second to the fourteenth day, and this finding persists for two weeks to three months. Downey described three types of abnormal lymphocytes in smears

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stained by the Wright modification of the Romanowsky method. The type I cells, which are most frequently seen, possess an oval, kidney-shaped, or lobulated nucleus with a coarse chromatin network. The cytoplasm is frequently non-granular and vacuolated or foamy in appearance. In the type II cells the cytoplasm is abundant and homogeneous. The nuclear chromatin strands are finer and often there are vacuoles. The type III cells are large and have many of the features of cellular immaturity with a fine chromatin pattern. In some instances nucleoli are present. The loss of refractive granules in the moist unstained specimen of blood to which neutral red has been added is said to be specific for infectious mononucleosis. This loss is normally found in 30 to 50 per cent of lymphocytes. The motility of all such abnormal lymphocytes in supravital preparations has been described as lymphocytic in type.

This abnormal peripheral blood picture may be present in a variety of diseases, such as infectious hepatitis, primary atypical pneumonia, rubella, rubeola, brucellosis, and other virus diseases. There is usually not as high a percentage of abnormal cells in these diseases, and they are usually not present in the blood for as long a time.

Serologic Findings

In my experience the presence of heterophile agglutinins of significant titer constitutes the most important diagnostic criterion. The heterophile antibodies found in infectious mononucleosis are sheep red cell agglutinins; they have also been found in normal serum, serum containing cold agglutinins, serum taken after horse serum or liver extract injections, and serum from patients with a variety of diseases. In infectious mononucleosis, they are present in high titer and are absorbed, 75 per cent or more, by beef red cell antigen but not by guinea pig kidney antigen (Table 1). There is not complete agreement on interpretation of antibody titers, however. Titer of 1:224 or higher on unabsorbed serum is considered positive for infectious mononucleosis when there are accompanying clinical signs and/or there

TABLE 1

Heterophile Antibody in Infectious Mononucleosis

Antibody	Antibodies Absorbed by Antigen	
	Guinea Pig Kidney	Boiled Beef Erythrocytes
Forssman heterophile antibody in normal serum	+	−*
Forssman heterophile antibody in serum sickness or horse-serum sensitization	+	+
Heterophile antibody of infectious mononucleosis	−**	+

+ = Complete absorption.
− = No absorption.
** = Frequent incomplete absorption.*
*** = Partial absorption may occur but titer should be only one or two tubes less than unabsorbed titer.*

is typical morphology of the smear of peripheral blood. Absorption of serum with guinea pig kidney and beef erythrocytes is indicated when: (1) There is a titer of 1:112 or less on unabsorbed serum and clinical and blood smear examination suggests infectious mononucleosis. (2) There is a titer of 1:224 or more on unabsorbed serum and clinical and blood smear examinations do not suggest infectious mononucleosis. (3) There is a titer of 1:56 or higher on unabsorbed serum and a history of horse serum injections.

In a study of 210 sporadic cases, Stevens, Bayrd, and Heck[6] found that in 91 per cent there was positive heterophile titer of 1:224, unabsorbed. Most of these were positive by the seventh day. The test may remain positive for more than three months or may become negative by the end of the second week of illness. It is obvious that failure to perform the tests early in the disease and failure to do repeated tests limit its usefulness. While a few well-documented cases without positive heterophile agglutination tests have been reported, the validity of such diagnoses remains to be established.[7]

Other Laboratory Tests

The bone marrow may contain abnormal lymphocytes or focal granulomas. Findings on liver function tests simulate those found in in-

fectious hepatitis. Other studies, such as serum electrophoresis, electroencephalography, spinal fluid examination, urinalysis, and the serologic test for syphilis, may be abnormal; but these findings are not of diagnostic importance.

Treatment

Unfortunately, there is no specific treatment for infectious mononucleosis. Strict isolation is unnecessary, since transmission from man to man by usual contact is unlikely. There is some clinical evidence that transmission by direct intimate oral contact is possible.[8] Absolute rest in bed or home confinement is important; the period of rest may vary from two weeks to three or more months, depending on the clinical course. The doctor's clinical judgment should determine the time of the patient's return to normal activities. Aspirin, extra fluids, and hot gargles should be used when indicated. While antibiotics do not alter the course of the primary disease, their use is important in treating the pharyngitis or other secondary infections. Infection with beta hemolytic Streptococcus, when present, should be treated with penicillin. Broad-spectrum antibiotics are useful in other cases.[9, 10] Corticotropin, cortisone, and related drugs are of value for treating spasmodic suffocation attacks accompanying severe pharyngitis and also for central nervous system involvement.[11, 12]

Characteristics of Cases Studied

The important characteristics of the sixteen sporadic cases studies at the Lexington Clinic are listed in Table 2. All persons had typical peripheral blood findings and a characteristic clinical course. Five had a heterophile agglutinin titer of 1:56 or less, but these cases were typical in other respects. No unusual characteristics were observed and no complications occurred. Broad-spectrum antibiotics were used in five; in all of these there was unusually severe pharyngitis. When an antibiotic is used, I believe that the dose should be large; for example, 750 mg. of oxytetracycline every six hours with cold milk was prescribed for these five people. All persons recovered uneventfully and there were no relapses.

TABLE 2
Characteristics of 16 Cases of Infectious Mononucleosis

Finding	Per cent of Cases
Fever	100
Posterior cervical nodes	80
Palpable spleen	66
Pharyngitis	60
Heterophile titer over 1:224	70*
Abnormal lymphocytes over 50 per cent	100

The titers in the remaining five cases were 1:7, 1:14 (two), and 1:56 (two). Unfortunately, absorption studies were not done in these cases.

Summary

Diagnosis of infectious mononucleosis is based on the proper clinical findings, lymphocytosis with abnormal lymphocytes, and the presence in the blood of a significant titer of sheep cell agglutinins.

There is no specific treatment for this disease, although antibiotics and steroids are frequently of value in individual cases.

Addendum

Since this paper was submitted for publication, I have seen two unusual complications of infectious mononucleosis. A 23-year-old man had spontaneous rupture of the spleen and recovered following splenectomy. A 17-year-old girl was seen who had associated Guillain-Barre syndrome. She was treated with steroids and recovered.

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Tetanus, Treatment and Prophylaxis*

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TETANUS is a disease that has been known to man since the time of Hippocrates 2300 years ago. Although it has never been common during peacetime in a civilian population, this condition assumes general importance because of its high mortality and morbidity and especially because it is preventable. The actual incidence of the disease is difficult to assess, but there are annually 400 to 600 deaths due to tetanus in the United States. Locally, at one of the three general hospitals in Lexington there have been nine cases in the past three years indicating that this is a problem most physicians will have to face during their professional careers.

The clinical disease tetanus results from the action of the neurotoxin of the Clostridium tetani bacillus. As is well known, the bacillus is an anaerobe present in the soil almost universally, which accounts for the higher incidence of tetanus in rural areas. The organism is most typically introduced by deep puncture wounds or at the time of massive tissue destruction, but in many reported cases the disease occurred after superficial abrasions and splinters. After an incubation period varying from two to thirty days, signs of the disease begin to appear. In Christensen's[1] series of patients from the Mayo Clinic, by far the most common presenting symptom was trismus, which occurred in 52%. Other common presenting symptoms are stiff neck and generalized rigidity. It is interesting to note that only 2% of these patients were presented with convulsions, but this should not be misinterpreted, because during their illness 78% of the patients had convulsive seizures and 99% had trismus.

Although all the symptoms of tetanus are due to increased neuro-muscular irritability, the exact mechanism of action of the neurotoxin is not known. The most recent work by Wright[2] and Brooks[3] would indicate that the neurotoxin reaches the central nervous system by way of the nerve trunks. There it produces its effects by selectively blocking inhibitory synapses in the central nervous system, allowing excitatory impulses to multiply and run at will through the reflex pathways.

The treatment of tetanus can be divided into the general care of the patient and the control of seizures. Concerning the general care, there is reasonable agreement among authors, but in regard to the control of seizures there are almost as many therapeutic regimens as there are authors.

General Care

The first objective in general care of the patient with tetanus is neutralization of the circulating exotoxin. Since the work of Cooke and Jones[4] this has been accomplished by giving a single large dose of antitoxin initially. Most clinics give between 60,000 and 120,000 units, with half of the total dose being given intravenously and half intramuscularly. (Injection of antitoxin locally around the wound is of questionable value.) This initial large dose provides a good antibody level for five to six weeks and eliminates the necessity of giving subsequent injections of horse serum at a time when the individual would have developed a hyper-sensitivity to the initial injection. When this passive immunity begins to wane in the fourth week, active immunization should be started.

The second objective is debridement of the wound harboring the causative organism. This can be accomplished by incision and drainage

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or by block excision if the lesion is not too large.

Antibiotic therapy is another point over which there is disagreement. Although Clostridium tetani is sensitive to penicillin in vitro, Altmeier[5] failed to show any beneficial effect on the clinical disease from the use of penicillin. Be that as it may, most clinics do use it in the treatment of tetanus. The use of prophylactic antibiotics in comatose patients has recently been questioned by Petersdorff and others,[6] who found a higher incidence of pulmonary complications in a prophylactically treated group than in a control group. They advocated treatment only after complications arose.

The general care of the patient also includes careful control of fluid and electrolyte balance. In the adult and older child, fluids can be given through either an indwelling polyethylene nasogastric tube or a gastrostomy, but in the small child or infant, most authors favor the parenteral route.

Because of the high incidence of both upper and lower respiratory obstruction secondary to spasm and accumulated secretions, tracheotomy has been advocated in care of the tetanus patient. Most large centers do not use it as a routine measure but advocate it for all but the patient with very mild involvement. The care of the tracheostomy of course introduces another problem, but its advantages in the control of secretions far outweigh its disadvantages. Generally speaking, the tracheotomy, debridement, venous cutdown, and administration of antitoxin can all be accomplished shortly after admission with the patient under general anesthesia.

Control of Seizures

The medications and therapeutic programs for control of seizures are manifold and varied. One of the drugs that has been used for many years is tribromethanol (Avertin®). This is given by the rectal route in a dosage of 80 mg. per kilogram of body weight initially, and then 20 to 60 mg. per kilogram are given every four to eight hours to maintain the patient free of tetanic spasms. The disadvantages of tribromoethanol mainly concern the route of administration for rectal drugs are absorbed in an inconsistent way and the drug itself is irritating and after a few days is apt to cause proctitis. Nevertheless this treatment will give excellent results, as seen in Cooke's[7] series, in which the mortality rate was 21.3%.

Another medication that has been used fairly widely in this country is thiopental (Pentothal® Sodium). This is usually given in a 0.2% solution as a continuous intravenous drip, with the rate of administration being governed by the clinical status of the patient. Generally after the second day the patient needs very small doses and can be maintained in a semiconscious state. This program too yields very good results, as seen in Forbes[8] report of 13 consecutive cases treated mainly with this drug without a death.

In the past five years, mephenesin (Tolserol®) has been widely mentioned as a therapeutic adjuvant. Last year Pinheiro[9] reported a series of 181 cases treated only with mephenesin by the intravenous route with a mortality rate of 23%. He initially gave 10 to 20 ml. of a 2% solution at 1 ml/min. to control seizures and then maintained patients by giving 6 to 18 gm. per day in their parenteral fluids. Usually after one week the drug could be given by the oral route with 2 to 3 gm. every four hours as the maintenance dosage.

Another newer drug employed for the control of tetanic seizures is chlorpromazine (Thorazine®). It has been used most extensively in Europe, when Ricci and associates[10] reported on 56 cases with a mortality rate of 25%. Adriani and Kerr,[11] however, reported on 11 cases from Charity Hospital in New Orleans with a mortality rate of 18%. The drug is used in conjunction with a barbiturate and meperidine (Demerol®) most commonly. When given this way in adults an inital dose of 25 to 50 mg. intravenously was effective for 6 to 24 hours, but succeeding doses had to be more frequent and larger to maintain the patient seizure free. Some authors have also suggested the use of hydrocortisone, but there seems to be little evidence from the statistics available to indicate that it is of any appreciable value.

Complications

The complications of tetanus can be divided into those due to the disease and those due to treatment. In the first category are laryngeal spasm and fractures, mainly of the vertebrae, due to the violent contractions. The complications incidental to treatment include oversedation, pneumonia, and atelectasis. The latter two should be particularly watched for when a tetanus patient's temperature suddenly spikes. The atelectasis can frequently be alleviated by low bronchoscopy through the tracheotomy stoma.

Results

Most of the reported series in this country are from large teaching centers with abundant house and nursing staffs. In comparing their results to those at one of our local general hospitals, we find that, although our cases are few, the mortality rate compares quite favorably.

Authors	Hospital	Year	Cases	Mortality
Adriani & Kerr[11]	Charity, New Orleans	'51-'54	100	30%
Cooke[7]	St. Louis Childrens	'33-'53	47	21%
Christensen[1]	Mayo Clinic	'45-'54	26	27%
	St. Joseph's, Lexington	'55-'57	9	33%

Of course in any general hospital with an open staff many different types of treatment will be employed. The following is a list of the various drugs used at St. Joseph's and the outcome. No inference is intended from this small number.

Drugs	Cases	Deaths
Phenobarbital	2	1
Seconal®	2	2
Amytal®	1	0
Amytal & Tolserol	2	0
Avertin & Thorazine	1	0
Nembutal® & Thorazine	1	0
	9	3

Immunization

The value of tetanus toxoid immunization has been well documented by the experience of the U. S. armed forces in World War II. The giving of 1500 units of tetanus antitoxin at the time of injury, however, has been questioned by various authors recently, since almost every sizable series contains at least a few patients who developed tetanus after this type of prophylaxis. Stafford and co-workers[12] also showed that the mortality rate for those developing tetanus in spite of prophylactic T.A.T. was the same as for those not receiving any T.A.T. The 1500-unit dose only produces slightly more than the protective level of antibodies, and this level begins to fall off as early as the seventh day; therefore the cases of tetanus developing in spite of prophylaxis can be accounted for by the lack of enough antitoxin to neutralize the toxin of the growing organism. The recent trend is to give 5,000 to 40,000 units of T.A.T. to the unimmunized person receiving a tetanus-prone wound.

In the past three or four years the duration and degree of active immunity have been studied, and the results are of particular interest to the physician treating a patient who was immunized many years before. Peterson and others[13] found that all of the individuals studied who had been immunized or had received booster doses within six years had a protective level of antibodies. They also showed that 70% of the people immunized 7 to 13 years previously had a protective level and only 5% had a level low enough to be considered serious risks. Even the ones immunized 13 years previously had a marked rise in antibody level following a booster dose, and this rise occurs within seven days. From these findings perhaps three conclusions can be drawn. First, at the time of a wound in a person previously immunized against tetanus, administration of tetanus toxoid alone is sufficient. Second, the duration of immunity is such that booster doses may be effective up to 13 years and probably longer after the last immunization. Third, the use of booster toxoid at the time of trivial injuries in persons receiving immunizing or booster doses within the previous five years is probably unnecessary.

Summary

Tetanus is a disease that constitutes a medical emergency. In the treatment of tetanus the physician should be thoroughly familiar with the principles of general care and with at least one of the effective methods of controlling seizures. In the treatment of tetanus it is my practice to sedate the patient with tribromethanol, perform a tracheotomy, debride the local wound, and perform a venous cut-down

in order to administer intravenously 50,000 units of tetanus antitoxin. Also, 50,000 units of tetanus antitoxin is given by the intramuscular route. The patient is then started on penicillin therapy. The administration of tribromethanol is continued in amounts necessary to keep the patient free of seizures. When the patient has recovered, active immunization with tetanus toxoid is begun.

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The Urgent Eye*

James Lee Stambaugh, M.D.**

Lexington, Ky.

URGENT eye conditions are those that require attention within a few hours. Aside from chemical eye injuries, there are probably no situations demanding emergency care in the same sense as cardiac or respiratory crises. Because this is generally appreciated, there is a tendency to procrastinate in the definitive treatment of eye conditions, some of which are exceedingly painful and some of which, if neglected, result in irreparable loss of vision and related ocular functions.

The commoner urgent eye situations, in order of decreasing urgency, are:

1. Chemical burns
2. Thermal and ultraviolet burns
3. Acute glaucoma
4. Perforating injuries
5. Ocular contusions
6. Corneal abrasions
7. Embedded foreign bodies
8. Corneal ulcers
9. Iridocyclitis
10. Herpes simplex corneae (dendritic keratitis)

Chemical Burns

Chemical burns demand the most immediate attention of all eye conditions. Minutes can spell the difference between useful vision and blindness. Acids damage the tissues instantly on contact, coagulating the protein; therefore it is possible to assess the extent of damage fairly accurately within hours or days after the injury. By contrast, alkalies continue to corrode the tissues for days or even months afterward. One should therefore be cautious in giving a final prognosis for alkali burns, since the eventual outcome may not be apparent for many months.



Figure 1

Regardless of the type of burn, the eye should be immediately and copiously irrigated with normal saline solution or, if that is not readily available, with tap water. Attempts at chemical neutralization contribute little if anything to the result. With an intravenous saline bottle attached high on a stand or held overhead, the nozzle on the tubing may be used to direct the stream into all portions of the eye. Particular attention should be given the fornices; since blepharospasm is frequently intense, a lid retractor aids greatly in this maneuver (fig. 1). Lime and plaster are common causes of alkali burns; in such cases every effort should be made to remove the solid particles hidden beneath folds of edematous conjunctiva. Application of a cycloplegic (2% or 5% homatropine) and an antibiotic (Neosporin®), both in solution form, completes the immediate treatment. The eyes may be covered with patches, or left open, with the patient wearing sunglasses while being transported to a specialist, who should see all but the most trivial chemical injuries.

*Presented at the Third Annual Fall Clinical Conference of the Lexington Clinic, October 22-23, 1958.

**Div. of Ophthalmology, Lexington Clinic.

Thermal and Ultraviolet Burns

Thermal eye burns are always associated with adjacent skin burns and require only an antibiotic ointment, a cycloplegic if severe, and patching. A severe thermal globe burn is rare, since the lids usually bear the brunt of injury and effectively protect the bulbus.

Ultraviolet burns of the cornea are excrutiatingly painful. Symptoms arise rather suddenly a few hours after exposure, quickly resulting in severe pain with blepharospasm, photophobia, and copious tearing. These situations frequently seem to arise about three or four o'clock in the morning, when the patient is awakened by the intense pain. The diagnosis is usually obvious from the history of exposure to a sunlamp or bright sunlight on the previous day. A single application of a local anesthetic drop should be followed by cycloplegics, antibiotics, and cod liver oil in either solution or ointment form. I do not recommend the repeated use of an analgesic ointment, because this retards the reparative process. Firm bandages relieve the pain considerably. Systemically given analgesics, sedatives, and soporifics should be used freely.

Acute Glaucoma

Acute glaucoma, which is rare before age forty, demands immediate attention to avoid permanent damage. The attacks begin quite suddenly with pain and redness in the eye, and blurred vision which progresses to a steamy haze and to blindness, with nausea and vomiting. The eye is intensely congested and stony hard; the cornea is steamy; the pupil is semidilated and fixed. Ophthalmoscopic examination may give a reflex that is dull red to black. Glaucoma must be differentiated from iridocyclitis, which is discussed below, and from conjunctivitis, which causes minimal pain and is usually obviously a superficial disease accompanied by mucopurulent discharge. If the diagnosis is certain, administration of miotics can be started, otherwise it is better to defer all local treatment until the patient can get to an ophthalmologist. Certainly an atropine-like drug should never be used. Morphine or Demerol® should be given intramuscularly if transport will require several hours. Definitive treatment consists of intensive use of miotics, administration of carbonic anhydrase inhibitors, and surgery.

Perforating Injuries

Perforating eye injuries, caused by a variety of sharp objects, generally result in surprisingly little pain, and the bleeding that occurs is self-limited. Lid-squeezing during examination may cause further damage; attempts to force the lids open for a better view should never be made. Removal of foreign matter should await arrival at the operating theater to avoid further damage from manipulation under uncontrolled conditions. Pieces of prolapsed uveal tissue look deceptively like foreign bodies, and I have seen attempted removal of such tissue result in dragging more intraocular tissue out through the wound. If a drop of antibiotic solution can be instilled without inducing squeezing, this is advisable; otherwise, nothing should be applied topically. In all cases, binocular dressings to preclude use of the sound eye should be immediately applied, and the patient should be gently transported, with his head elevated, to his place of definitive treatment.

Ocular Contusions

Ocular contusions are one of the most treacherous eye conditions frequently seen. The chief danger lies in secondary hemorrhage, which occurs from a few hours to a few days after injury and may be very extensive. The condition of a contused eye can look quite benign when first seen shortly after a blow by a blunt object, but it should never be lightly regarded. Such an eye should be treated with the same respect given a perforating injury. It is best to use no topical medication, to completely cover both eyes, and to keep the patient in bed and quiet, with mild sedation and soporifics if necessary, until the initial damage is well cleared up. Atropine is definitely contraindicated, since its use increases the possibility of further bleeding. The retina should be scrupulously examined; edema, hemorrhage, or detachment are warnings for the closest of supervision. Before the patient's dismissal, the visual acuity should be determined and any deficiencies adequately explained. At the Lexington Clinic we have seen several instances in which relatively light blunt blows to the eye resulted in permanent loss of central vision to levels below 20/200, due to macular damage by a

contrecoup mechanism. Intraocular hemorhage, if massive, tends to produce secondary glaucoma—a complication requiring immediate surgical correction.

Corneal Abrasions

Corneal abrasions are very painful; those caused by paper edges or fingernails seem especially so. Usually the patient is aware of the cause, but sometimes he will awaken to find his eye painful, red, tearing, and light-sensitive, and will have no adequate explanation. Probably such injuries result from an accidental pass over the eye with a bedsheet edge or fingernail, and it is in such situations that fluorescein has its greatest usefulness. This staining agent in solution, however, is quite prone to nurture pyocyaneus bacilli, which cause an especially dangerous type of corneal ulcer. Possible danger can be avoided by dipping filter-paper halfway into a little fresh 20% fluorescein solution, cutting it when dry into strips ¼ by 1 inch, putting the individual strips in little bottles with screw caps, and sterilizing them. The strips are then used as needed, by touching the stained end of the paper to the inferior conjuctival cul-de-sac for a few seconds (figs. 2 and 3).



Fig. 2

Corneal abrasions are treated with a bacteriostatic solution topically (such as Gantrisin® or Neosporin®), a mild cycloplegic if there is considerable epithelial damage (2% or 5% homatropine), and a firm bandage. A local anesthetic (such as the indiscriminately prescribed butyn ointment preparations) should never be used, either for office or for the patient's home application, since all local anesthetics damage corneal epithelium and delay its regeneration. Pain is properly controlled by systemically given medicaments.



Fig. 3

Embedded Foreign Bodies

Many foreign bodies are washed out in the flood of tears, but those which remain embedded in the cornea are quite irritating. Their prompt removal avoids the complications of keratitis and infection with ulceration and abscess. Oblique illumination is helpful in detecting them. A most useful and readily available tool for extracting foreign bodies is a 23 to 25 gage hypodermic needle, which during local anesthesia can be passed beneath the object to lift it out. Foreign matter in the cornea should never be repeatedly poked at with a cotton applicator; this invariably causes additional damage. If the raw area is tiny, after removal of the object, the eye may be left open and a bacteriostatic solution prescribed to be used every hour. With larger raw areas, the eye should be firmly patched after instilling bacteriostatic and weak cycloplegic solutions. It is preferable not to use ointments in such cases, as they tend to retard re-epithelialization and occasionally globules of the ointment base will become entrapped beneath the regenerated epithelium. In all cases the eye should be carefully observed for signs of infection, which requires rigorous treatment at the first indication.

Corneal Ulcers

Corneal ulcers are the result of uncontrolled invasion through a break in epithelial continuity. Their severity has often been increased in recent years by an unfortunate tendency to treat obscure eye conditions with a parade of antibiotics and steroid preparations without proper regard for the basic pathology. Especially noteworthy has been the increase in mycotic corneal infections as the result of this injudicious practice. A corneal ulcer can usually be readily recognized by a gray infiltration surrounding a concave defect of the surface, with an accumulation of mucus and pus. Pain is not necessarily severe. There is frequently a history of preceding trauma or foreign body. Many corneal ulcers require bacteriological study, and they are best handled by a specialist.

Iridocyclitis

Iridocyclitis occurs at any age; recurrent attacks are especially troublesome. The onset is usually less dramatic than in glaucoma, being measured in days rather than hours; there is less pain and less visual disturbance. Gradually the eye becomes red, the vision becomes blurred, and there are varying degrees of photophobia. The pupil becomes smaller than its fellow and more or less fixed, and the iris assumes a general murky haze with indistinct markings. The fundus may be seen well or not at all. Classically, the eye is soft, but ensuing secondary glaucoma may confuse the picture. Early treatment prevents the damaging complications of adhesions, cataract, glaucoma, and inflammatory membranes, with consequent loss of vision. If the diagnosis is certain, cycloplegics and locally applied steriods should be used liberally. As the treatments for iridocyclitis and acute glaucoma are diametrically opposed, it is obvious that refraining from local medication is preferable to using the wrong kind in doubtful cases in which the diagnosis cannot be established by the gross methods at hand. The patient's interests are therefore better served by awaiting consultation rather than by ill-advised use of powerful drugs which cannot be counteracted.

Herpes Simplex Corneae

Herpes simplex of the cornea is one of the most troublesome eye conditions because it is difficult to treat and tends to recur. It arises spontaneously or begins in an area of cornea previously traumatized, spreading through the epithelium to produce, classically, an arborescent pattern. Some cases, however, never exhibit a dendritic figure. An eye which continues to show fluctuating amounts of irritation and redness should be considered suspect, even if the injury to it was trivial. Sometimes a "cold," some relatively minor infection, or an emotional upset will trigger an attack or recurrence. Redness, photophobia, tearing, and blepharospasm are present in varying degree. Fluorescein frequently helps in the diagnosis; in the classical situation an arborescent design is demonstrated by staining.

Locally applied steroids in any form are contraindicated in herpes simplex. They should not be routinely used in the treatment of even small corneal foreign bodies or abrasions, since herpes simplex sometimes develops from the site. At the Lexington Clinic, we are seeing more and more cases of herpes simplex corneae, which I feel is due at least in part to the indiscriminate use of steroid eye preparations. All patients with herpes simplex keratitis are probably best handled by an ophthalmologist, for even at best the outcome is not always happy.

For everything you have missed, you have gained something else; and for everything you gain, you lose something.

—Ralph Waldo Emerson

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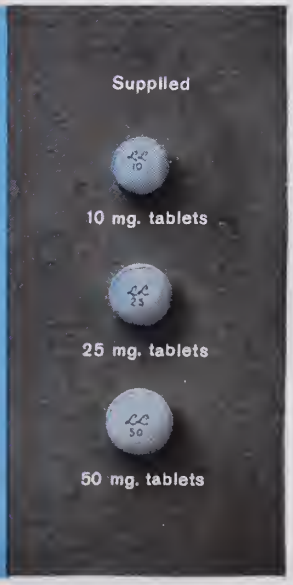
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Renal Hypertension*

Joseph E. Maurer, M.D.**

Louisville, Ky.

HYPERTENSION may result from certain renal diseases, a few of which may affect only one kidney. In such cases surgical cure of the hypertension may be effected by removal of the diseased kidney. Although these cases are few in number, they are important, for if one excludes certain other infrequent but definite causes of hypertension such as coarctation of the aorta and pheochromocytoma, the urologist has so far demonstrated the only proven permanent cure. It appears that surgery is helpful in about 2% of all hypertensive patients.

The pathogenesis of renal hypertension is not understood. Many studies have resulted in conflicting data. However, in almost all studies, hypertension having an apparent renal basis is coexistent with a reduction in the functioning renal mass. Renal diseases resulting in hypertension in which cure was obtained by unilateral nephrectomy are summarized in the table below.

Pathogenesis	Total
Pyelonephritis	62
Pyonephrosis	4
Atrophic kidney	18
Hydronephrosis	23
Tuberculosis	6
Ureteral occlusion	2
Perirenal hematoma	2
Renal cyst	2
Hematogenous cyst	1
Renal tumor	5
Radiation sclerosis	1
Infarct	3
Thromboangiitis obliterans	1
Intrarenal vascular sclerosis	1
Aneurysm of renal artery	4
Arterial occlusion	10
Not specified	4
Total	149

*Presented at the Norton Memorial Infirmary, Postgraduate Medical Seminar in Louisville on December 18, 1958.

**Instructor in Urology, U of L School of Medicine.

Diagnosis

Diagnosis of renal hypertension may usually be made by pyelography. Intravenous urography may reveal an abnormal or nonfunctioning kidney. The diagnosis is confirmed if necessary by retrograde studies. It has been shown that simultaneous measurement of the sodium or creatinine excretion by each kidney correlates with the expectation of cure by nephrectomy. Those patients cured by nephrectomy have invariably shown decreased urine flow and reduced sodium or creatinine concentration in urine collected from the affected side, as compared with the urine from the opposite side. On the other hand, patients who did not improve following nephrectomy have not shown these changes, nor have patients who were later proven to have bilateral renal disease. To be significant, the reduction in sodium concentration should be greater than 20%.

Criteria of Cure

Dr. Homer W. Smith, of New York University, who prepared the table referred to above, has put forth several criteria for classification of cure. First, there must have been a true hypertension existing over a period of time with multiple blood pressure recordings, exceeding 140/90. Secondly, the postoperative patient must be followed at least a year with blood pressure not exceeding 140/90. The long follow-up period is essential, for quite often hypertension will be relieved temporarily by nephrectomy (or other major surgery) only to recur in a few months.

At the present time, it seems clear that nephrectomy for the cure of hypertension should be done only when there are clear-cut urological indications for the procedure. Hypertension per se should not be the indication for nephrectomy.

CHILDREN'S HOSPITAL

Chronic Nephritis*

Present Illness

J. T., a fourteen-year-old white girl, was admitted to the Pediatric Service of the Children's Hospital on March 3, 1959 with the chief complaint of lethargy.

In September of 1957 the child's parents were called by her school teacher and told that she appeared to be anemic. In February of 1958 this girl was taken to the Emergency Room of General Hospital. Subsequent studies revealed a hemoglobin of 9.6, and intramuscular iron was administered. She was asked to come back to the clinic for follow-up but did not. Since June of 1958 the child has been described by her mother as walking "like an old woman." She would not climb stairs as this tired her. Since starting school in September of 1958 she has been continually complaining of being tired and has been noted during class to frequently slump over asleep on the desk. Her mother notes that since the Fall of 1958 she has gotten much paler.

Past History

In June of 1946, at age thirteen months, she was admitted to General Hospital with a diagnosis of diarrhea and at that time was found to have 4+ albumin and many white cells in her urine. She was treated for a short time with sulfadiazine. Ten days after discharge from the hospital she was readmitted with diarrhea and severe dehydration and again found to have 2+ albumin and white cells in her urine. On this admission she weighed only twelve pounds, although thirteen months old.

Physical Examination

On admission this girl was friendly, cooperative, quiet, and appeared chronically ill. In her own words, "I do not have any energy to do very much." Her weight was sixty-one pounds and her height was fifty-five inches. Both of these are less than the 10th percentile for her age. Her temperature was 98.6; pulse—88; respirations—24; blood pressure—140/90. This child's palor was the most striking thing noted. Her fundi were normal. She had a few enlarged anterior cervical nodes. Her heart and lungs were normal to examination. Her liver edge was down one finger breadth, and no other abdominal masses were palpated. Her genitalia were under developed, and pubic and axillary hair were scanty. She had a mild lumbar kyphosis and a moderate scoliosis. Neurological examination was negative.

Laboratory Examination

Admission hemoglobin was 6.6 grams; white count—8,750; 51% segs.; 5 stabs.; 36 lymphs.; 3 monos.; and 5 eosinophils. A reticulocyte count on admission was 0.8%. Many urinalyses were obtained, and the specific gravity ranged between 1010 and 1015—never any higher. She had 300 to 1,000 milligrams per cent of albumen in almost all her urines. There were 5 to 6 white and red cells in all the urines. The urine PH was usually 5.5. One Sulkowitch test on the urine was reported as negative. Serum NPN—141; calcium—3.4 milliequivalents; CO^2 capacity—11.4 mM/L; chlorides—109 milliequivalents, alkaline phosphatase—12.5 Bodansky units; phosphorous—9.5 milligrams per cent; potassium—4.4 milliequivalents; sodium — 118 milliequivalents — total protein—7.6 grams per cent; albumin—4.2; globulin—3.4.

Discussion

Alex J. Steigman, M.D., Chairman, Department of Pediatrics:

From the information given one can say on pretty firm ground that this child has chronic advanced renal failure. In June of 1946 when seen for diarrhea there was evidence pointing toward kidney involvement, not only from

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Department of Pediatrics, University of Louisville School of Medicine.

the urinary findings, but also from the marked weight retardation, as she weighed only twelve pounds at thirteen months of age. One wonders if appropriate bacteriological and urological investigations done at that time might have disclosed a correctable lesion, e.g. genito-urinary anomaly with secondary bacterial infection. Chronic pyelonephritis ensues when such lesions are undetected and untreated. Numerous growth, metabolic, secondary cardiovascular and renal changes of a fixed nature result as in the child before you today. Also, vascular anomalies best demonstrated by retrograde aortography may be associated with renal defects. If this child has one of these anatomical defects, attempts to correct it surgically could prove life-saving even with her far advanced renal decompensation. Her prognosis, however, is dismal.

Robert Lich, Jr., M.D., Chief, Section on Urology:

Under pentothal anesthesia this child's bladder was visualized and found to be entirely normal except for a few red punctate areas of no significance. Uretheral catheters were introduced into both kidneys, and the resultant urograms (Figure 1) revealed far advanced bilateral atrophic pyelonephritis. This case is an outstanding example of this disease, and it should be remembered that there was less than 2 cc. of dye injected on each side. In view



Figure 1
Retrograde pyelogram demonstrating small contracted kidneys with distorted collecting systems classical of a bilateral atrophic pyelonephritis.

of these findings I would feel that further studies, such as biopsy, are not indicated and would be very hazardous. It is also interesting to note that there are changes in the sacroiliac joints consisting of some irregular reabsorption, particularly in the lower parts of the joint area. The anterior ends of the lower ribs are also well seen on the abdominal films and show some splaying in regularity at the costochondral junctions. These changes are certainly consistent with secondary renal rickets.

Katharine Dodd, M.D., Distinguished Professor of Pediatrics:

From what all the rest of you have said, and from the history and laboratory findings it seems apparent that we have a patient who has chronic kidney disease with renal acidosis and evidence of early renal rickets. It seems that she has no anatomical defects that can be corrected. It certainly may be of some value to try to culture this child's urine and treat any residual infection that still may be present. The big problem in this child is treatment for chronic renal failure in order to try to make her more comfortable. The anemia can best be treated with packed red cells, and an elevated hemoglobin may do more than anything else to restore some of this child's vitality. It may be difficult to keep a hemoglobin level near normal, and we may have to settle for something in the range of seven or eight grams per cent over a long period of time.

Anemia in chronic nephritis seems to be from bone marrow suppression. It is evident that this child has renal tubular disease because of her inability to concentrate her urine as shown by consistent low specific gravity. Careful tabulation of her water intake and output may be of significance. An increase in her water intake may be necessary in order for her to help remove some of her waste products. The elevated, nonprotein nitrogen is evidence of glomerular damage. The elevated phosphorus is further evidence of glomerular damage. Because of phosphorus elevation, the parathyroid glands are stimulated to secrete their hormone and consequently calcium is removed from bone. The removal of calcium from bone in adults gives you the picture of osteitis fibrosa cystica, and if this same process were to occur in a child it would be called rickets. It is of interest to note that this patient's serum calcium is low, and the reason for this is not clearly understood. The elevated alkaline phosphatase is commonly seen in diseases where there is rapid removal of calcium from bones.

General Plan Suggested for Treatment of Patients with Chronic Renal Insufficiency

1. Correct the anemia with packed red-cell transfusions at intervals that seem appropriate to keep the patient comfortable.

2. When there is no evidence of anuria and/or when there is polyuria with inability to concentrate, an increase in fluid volume may be helpful for eliminating waste products.

3. Alkalinizing solutions to overcome the acidosis may be of help, and we have found a mixture of citric acid—140 grams, sodium citrate—98 grams, distilled water to make 1,000 cc. is a good and palatable mixture which contains one milliequivalent of sodium per cc. One would usually start in a child to give approximately 50 cc. a day of this mixture in two divided doses. This amount will have to be varied for the child's age and the child's response clinically and chemically.

4. Calcium gluconate from four to eight grams a day orally will help to avoid tetany. This child's calcium is already low, and when acidosis is corrected the circulating ionized calcium becomes less; consequently these patients may develop tetanic spasms.

5. Vitamin D in doses of 1,000 to 5,000 units a day may be given to help increase the absorption of calcium from the G.I. tract.

6. Milk should be restricted to two glasses a day, because one must remember that the phosphorus to calcium ratio is high in milk. We do not want these patients to have additional phosphorus.

7. In order to decrease the phosphorus intake an aluminum hydroxide product such as Amphojel before each meal in the form of two or three tablespoons may be helpful in reducing phosphorus absorption.

8. Diet is a most controversial point of treatment. I feel that a diet should contain probably no more than a gram of protein per kilogram and also be high in carbohydrates.

At best this child's prognosis must be very guarded. It is important that she is carefully followed by one physician who will try the above as they are needed to make this child more comfortable. It cannot be over emphasized that early diagnosis in renal disease, be it obstruction or infection, is most important. Only with adequate treatment after proper diagnosis can some of these patients be spared the state of chronic nephritis.

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EDITORIALS

Now Is The Time To Support U of L

THE University of Louisville campaign for two and one-half million dollars for capital expenditures is now in full swing. Approximately 60% of the entire amount is earmarked for the medical and dental schools. In fact, the President and the Board of Trustees of the University have agreed that the first $1,489,585 of undesignated pledges will be used to match funds from the Federal Government to build a Medical-Dental Research Building and a new cancer treatment center. Furthermore, the proposed Medical-Dental Research Building is but the first unit of a modern Medical School center, which will include a new Medical-Dental Instructional building, a new auditorium, a new library, and eventually a University Hospital.

Many doctors have asked why a research building is being constructed instead of the much needed medical instructional building. The answers can be summed up in two statements:

1. There are matching federal funds available for construction of the research building, but no such funds are yet available for an instructional building.

2. Space for research is urgently needed, not only for the programs presently underway at the school, but also for expansion of these and for the development of many new projects.

As a matter of practical importance this new research building will free a great deal of space in the present instructional building, so that the teaching laboratories, offices, library, and the student lounge can be expanded and modernized.

It is unnecessary for us to emphasize the importance of research to the well-being of the whole medical school structure. Without it our teachers and students would deteriorate; without it the progress of modern medicine would be halted in its tracks. An aggressive research program carried out on many different fronts invigorates immeasurably both undergraduate and postgraduate teaching programs.

There are many reasons why physicians who have close ties with the University of Louisville Medical School should give generously to the current campaign. Medical Alumni particularly, since they received their education for only a fraction of what it cost the University to provide it, should respond promptly and wholeheartedly. The spontaneous enthusiasm shown by the Freshman class which pledged over $86,000 to the Medical School through the Medical Alumni Association should be a guide post to the size of the contribution which every medical school alumnus, young and old, should strive for.

The University has emphasized that gifts may be spread over three years and that they are tax deductible. The University also points out that gifts may be made not only in cash, but also in securities. In many cases the latter will be far less expensive for the giver, since he will not have to pay any tax on an increase in value.

Undoubtedly a number of doctors have been expecting to make a major gift some day to the Medical School, but have been waiting for the time when the gift will count for the most, and will help the school in a permanent way. That time has come, when medical alumni, friends of the University, and teachers in the Medical School should do their part by donating generously and making this campaign a rousing success.

R. Glen Spurling, M.D., Chairman
Campaign Medical Division
J. Murray Kinsman, M.D., Dean
U of L School of Medicine

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

Mental Health in Kentucky

IT is most appropriate to evaluate mental health in Kentucky at this time. We are undoubtedly on the threshold of great medical advances and scientific discoveries. The various governmental agencies, private civic programs, volunteer workers and the populace as a whole are acutely aware of the needs of the mentally sick. Every physician is striving to learn of the new tools available for the treatment of emotional and mental illness. Our invaluable friends of pharmacy are close at hand and in many cases are leading the way with research to a more secure maturity and old age.

Kentucky has not been remiss in her contributions. Our Commissioner of Mental Health and his physicians at the mental hospitals have been working diligently to improve both the physical plant and the medical care rendered to the sick. There is a noticeable effort to look into not only the medical requirements but also the aesthetic needs of each patient. Increased cleanliness, cheerful color schemes, removing of bars, and opening of doors are some of the progressive steps being taken.

The use of therapeutic advances on mental illness consists of the tremendous armamentarium of ataractic and related drugs. These have noticeably reduced the populations of state hospitals, since continued efforts are being made to follow up discharged patients and to evaluate the best drug for each case.

In addition to these most important aspects of health, Kentucky is able to develop the economics that are so necessary to giving efficient care to the mentally ill. There are more positions for physicians, graduate nurses, and aides of all types. In fact, the salary scale is such that financial remuneration for graduate nurses is better than in private general hospitals.

According to a recent bulletin, the Department of Mental Health is operating or contributing materially to the operation of eighteen mental health clinics. These clinics stimulate interest in the community programs and help to educate the public generally about mental illness and health. This encourages more people each year to avail themselves of services offered or available through some source.

The Kentucky Association for Mental Health has done yeoman service for Kentuckians. This group of interested laymen and professional people keeps before the public the possibility that each one of us can participate in this most vital and interesting program. Membership in this organization offers a most enticing and pleasant way to be of service to humanity.

Bridgehaven, another community service that is most welcome to the mental patient, is a recent adjunct to the treatment and rehabilitation of the convalescent patient. This is a center where the patient who is leaving the hospital can pick up the threads of social life and weave a pattern to regain his place in the affairs of everyday living. Here he finds pleasant association with others who are likewise interested.

The private psychiatrist is also contributing to this picture. Despite Kentucky's limited per capita economy we can boast of private psychiatric facilities in Louisville, Lexington, and Covington that compare favorably with the best in the nation. With these private psychiatric beds we attract patients from ten or more states surrounding us.

All of this adds up to a more attractive climate for the treatment of mental illness. Patients who once had to anticipate years or even a lifetime in the mental hospital now can look forward to only a few weeks or months therein, or better still the possibility for many cases of outpatient treatment with no loss of time away from family or work. Certainly every physician can take satisfaction in the knowledge of these tremendous advances and his opportunity to participate in the recovery of our mentally ill.

Louis M. Foltz, M.D.

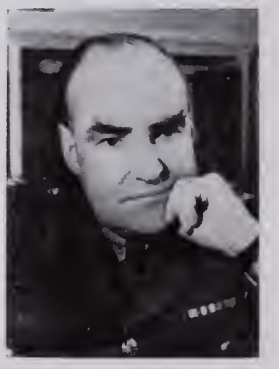
ORGANIZATION SECTION

1959 Guest Speaker Information Released by Dr. Robertson

Information on four of the featured speakers on the scientific program of the 1959 Annual Meeting on September 22, 23, and 24 has been announced by Robert W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements.

Included in his announcement were Campbell McGregor Gardner, M.D., Montreal, guest of the Kentucky Chapter, American College of Surgeons; Robert L. Nesbitt, Jr., M.D., Albany, N. Y., guest of the Kentucky Obstetrical and Gynecological Society; William A. Sodeman, M.D., Philadelphia, Pa., guest of the Kentucky Chapter, American College of Physicians; and Kenneth L. Stratton, M.D., of New York City, who will cover some phase of medicine in the space age.

Doctor Gardner, a native of Montreal and a graduate of McGill in 1931, is chief surgeon at Queen Mary Veterans Hospital, associate-surgeon at Montreal General Hospital and assistant professor of surgery at McGill University. He took over his present positions after retiring from the Canadian Army with the rank of Lieutenant Colonel.



Dr. Gardner

His topic before the general session on Wednesday afternoon will be "Chronic Inflammatory Lesions of the Large Bowel." Doctor Gardner will also be one of the participants in a panel on "Biliary Tract Disease" at the opening session of the meeting.

A 1947 graduate of Vanderbilt Medical School, Nashville, Doctor Nesbitt is presently professor and chairman of the Department of Obstetrics and Gynecology at Albany Medical College of Union University. Selected as one of ten Outstanding Young Men in America by the U. S. Chamber of Commerce, Doctor Nesbitt is the author of numerous articles on obstetrics and gynecology.



Dr. Nesbitt

He took his residency training at Johns Hopkins Hospital and from 1955-6 he was acting head of the Department of Obstetrics at Johns Hopkins. His topic during the general session on Wednesday afternoon will be "Detection and Diagnosis of Early Cervical Cancer."

Doctor Sodeman will spcak on "Problems in Recognition of Acute Pericarditis" during the Wednesday afternoon program and will participate in a panel discussion on "Reversible Renal Failure" on the closing day of the meeting.



Dr. Sodeman

Dean of the Jefferson Medical College, he was Magee professor of medicine and head of the Department of Medicine at the college. He attended the University of Michigan Medical School graduating in 1931 and interned at St. Vincent's Hospital, Toledo, Ohio.

"The Practical Application of Medicine to Jet Transportation" will be the topic discussed by Doctor Stratton, medical director of American Airlines who will address the Wednesday afternoon session. A graduate of the University of Louisville School of Medicine in 1935, Doctor Stratton was in private practice in northern Kentucky and southern Ohio until 1942 when he joined the Army Air Force.



Dr. Stratton

Doctor Stratton was flight surgeon in the Alaskan Division of the Air Transport Command. He retired from active duty in 1946 and became a member of the medical staff of American Airlines in the Western Region. Two years later he was made medical director of the line, stationed in New York City.

Nominating Comm. Names Chrm.

James Archer, M.D., Paintsville, was re-elected chairman of the KSMA Nominating Committee at a meeting of the committee in Lexington on March 26. Other members of the committee which will nominate officers of the KSMA for 1959-60 are: Joe M. Bush, M.D., Mt. Sterling; J. B. Marshall, M.D., Louisville; Wendell V. Lyon, M.D., Ashland; and Gaithel L. Simpson, M.D., Greenville.

Preliminary Program for 1959 Annual Meeting, Released by Committee on Scientific Assembly

Tentative program for the 1959 Annual Meeting on September 22, 23, and 24 was released recently by Robert W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements. Beverly T. Towery, M.D., Louisville, is in charge of programming.

Tuesday, September 22

8:45—9:00 Opening Ceremonies

9:00—9:20 "Tendon Injuries of the Hand"
S. Benjamin Fowler, M.D., Nashville, Tenn.
Guest, Kentucky Orthopaedic Society

9:20—9:40 "Thoracic Emergencies in Infancy and Childhood"
Herbert Sloan, M.D., Ann Arbor, Mich.
Guest of Ky. Chapt., Am. Coll. of Chest Physicians

9:40—10:00 President's Address
Robert W. Robertson, M.D., Paducah

10:00—10:30 Visit Exhibits

10:30—11:50 Panel—"Biliary Tract Disease"
Malcolm M. Stanley, M.D., Louisville, moderator
Edna Ettinger, M.D., Boston, Mass.
Campbell Gardner, M.D., Montreal, Que.
Guest of Ky. Chapt., Amer. Coll. of Surgeons
Daniel C. Moore, Seattle, Wash.
Guest of Ky. Anesthesiology Society

11:50—2:00 Luncheon

2:00—4:30 Meetings of Specialty Groups
Ky. Chapt., Amer. Academy of Pediatrics
Ky. Chapt., Amer. Coll. of Chest Physicians
Ky. Orthopaedic Society
Ky. Ob.-Gyn. Society
Ky. Chapt., Am. Coll. of Surgeons
Ky. Anesthesiology Society

Wednesday, September 23

9:00—9:20 "Forensic Pathology, The Function and Responsibility of the Coroner's Office"

9:20—9:40 "Evaluation of Growth and Development in Children"
Nelson K. Ordway, M.D., New Haven, Conn.
Guest of Ky. Chapt., Am. Academy of Pediatrics

9:40—10:00 "Recent Advances in Gastrointestinal Roentgenology"
Richard Harvey Marshak, M.D., New York, N. Y.
Guest of Ky. Radiological Society

10:00—10:30 Visit Exhibits

10:30—11:10 Clinicopathological Conference
Robert J. Ritterhoff, M.D., Covington
John D. Allen, Jr., M.D., Louisville

11:10—2:00 President's Luncheon

2:00—2:20 "Chronic Inflammatory Lesions of the Large Bowel"
Campbell Gardner, M.D., Montreal
Guest, Ky. Chapt., Am. Coll. of Surgeons

2:20—2:40 "Pedodontics Grows Up: The Science of Dentistry for Children"
Henry M. Wilbur, D.D.S., Louisville
Ky. Dental Association Representative

2:40—3:00 "Detection and Diagnosis of Early Cervical Cancer"
Robert E. L. Nesbitt, Jr., M.D., Albany, N. Y.
Guest, Ky. Ob.-Gyn. Society

3:00—3:30 Visit Exhibits

3:30—3:50 "Problems in the Recognition of Acute Pericarditis"
William A. Sodeman, M.D., Philadelphia, Pa.
Guest, Ky. Chapt., Am. College of Physicians

3:50—4:10 "The Practical Application of Medicine to Jet Transportation"
Kenneth L. Stratton, M.D., Flushing, N. Y.

4:10—4:30 "Diagnosis and Treatment of the Red Eye" (with movie)
John H. King, M.D., Washington, D. C.
Guest, Ky. EENT Society

4:30 Motion Picture
"Whale ECG"
Walker Laboratories

Thursday, September 24

9:00—11:50 Specialty Group Meetings
Ky. Chapt., Amer. Academy of Gen. Practice
Ky. Chapt., Amer. College of Physicians
Ky. EENT Society
Ky. Psychiatric Association
Ky. Public Health Physicians

11:50—2:00 Lunch

2:00—2:20 "Building an Effectual Physician-Psychiatrist Team"
Robert S. Garber, M.D., Belle Mead, N. J.
Guest, Ky. Psychiatric Association

2:20—2:40 "Cancer Control"
Rod J. Heller, M.D., Bethesda, Md.
Guest, Ky. Publ. Health Physicians

2:40—3:00 "The Clinical Use of the Oral Nitrogen Mustard Compounds in Malignant Diseases"
Wayne R. Rundles, M.D., Durham, N. C.
Guest, Ky. Chapt., Amer. Academy of General Practice

3:00—3:30 Visit Exhibits

3:30—4:30 Panel—"Reversible Renal Failure"
Beverly T. Towery, M.D., Louisville, moderator
William A. Sodeman, M.D., Philadelphia, Pa.
Wayne R. Rundles, M.D., Durham, N. C.
Peter C. Pellegrino, M.D., Lexington, Ky.

McDowell Apothecary Dedication Set for August 15

The McDowell Apothecary Shop in Danville will be officially dedicated in ceremonies on August 15, according to Francis M. Massie, M.D., Lexington, co-chairman of the KSMA McDowell Home Committee.

The Kentucky Pharmaceutical Association is sponsoring the dedication, which will be held in conjunction with the national meeting of the American Pharmaceutical Association in Cincinnati on Thursday and Friday of that week. In 1956, the KPA gave the KSMA $10,000 to buy the apothecary and the property adjoining the McDowell Home. At that time, Eli Lilly Company, Indianapolis, donated $20,000 to its restoration.

Work on the apothecary and grounds was scheduled for completion by June 1 of this year, according to Doctor Massie. Technical advice on the restoration was given by the Smithsonian Institute, whose representatives made sure that every feature of the apothecary reflects the McDowell period.

June 25 Date of 7th Dist. Meet at Frankfort C. C.

June 25 is the date of the annual dinner meeting of the Seventh Councilor District of the KSMA at the Frankfort Country Club, according to Wyatt Norvell, M.D., New Castle, district councilor.

The meeting is scheduled to begin at 4 p.m. (CD ST) and will include scientific presentations by E. S. Weaver, M.D., Carrollton; and Livingston A. Wahle, M.D., Shelbyville. Others featured on the program include: Robert W. Robertson, M.D., KSMA president; E. Gaines Davis, KSMA legal counsel; and G. N. Combs, M.D., Pikeville.

Full program of the meeting appeared in the May issue of the Journal.

PG Opportunities in Ky. Listed for Second Quarter

Postgraduate medical opportunities available from July through September were announced recently by Walter Coe, M.D., Louisville, chairman of the KSMA Committee on Postgraduate Medical Education.

Purpose of the quarterly report on postgraduate medical activities is to keep physicians up-to-date on coming events in that field. In announcing the schedule, Doctor Coe pointed out that the summer months are traditionally a slack period for PG activities.

Following is the list that had been received at press time.

July

2 Second Councilor District Meeting, Henderson Country Club, starts at 6:30 p.m.

16 KAGP Big Sandy Seminar, Paintsville Country Club, Paintsville

September

22-24 KSMA Annual Meeting, Columbia Auditorium, Louisville—12 Specialty Group Meetings

Council's 7 Points Aimed at Solving Problems of Aged

In order to meet the problems of the aged on a local level, the KSMA Committee on Problems of the Aging, headed by Robertson O. Joplin, M.D., Louisville, presented seven recommendations to the KSMA Council for approval.

The following recommendations, aimed at solving the problem of the aged in Kentucky, were approved by the Council.

1. That the KSMA offer to work with the nursing homes in Kentucky for the purpose of:

(a) Getting more new constructions.

(b) Improving and enlarging present facilities.

2. That the KSMA investigate the possibilities of using the Hill-Burton and other funds to erect adequate facilities, in conjunction with, adjoining, or near established general hospitals for the convalescent and rehabilitation of the aged. Equipment for these buildings would not be elaborate, since heating, laundry, kitchen, and other facilities of the hospital might be used. Savings in utilization of certain hospital personnel in supervisory capacity might be possible. Also, X-ray, Surgical Pavilion—elaborate Laboratory series would not be needed.

3. Investigate the possibility of getting state aid for assistance to nursing homes.

4. Request cooperation of the KSMA Committee on Public Information and Service, and the AMA Bureau of Health Education in developing an educational program which would include the following:

a. Locate and catalog information, visual aids, Etc., that could be used by medical societies, civic clubs, and other lay organizations.

b. Set up speakers bureau in larger communities.

c. Distribution of spot announcements to radio and TV stations at appropriate times.

5. Encourage county medical societies, especially in larger counties such as Jefferson, Fayette, Campbell, Kenton, etc., to develop local programs of education in the geriatrics field.

6. Investigate the development of a program which would provide for a visiting nurse service for the chronically ill among our senior citizens in the homes. The service would be operated under the supervision of family physicians and might be worked out through the community chest or an independent agency. A nominal charge would be paid by the family for each visit.

7. Investigate the possibility of setting up a training program for the training of families caring for their aged in their own homes. (It was suggested that often the aged are unhappy as well as the younger members of the family, due to improper understanding and appreciation of the problems of the other members of the family.)

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SEARLE

Second District Meets July 2 at Henderson C. C.

"The Handling of Mass Civilian Casualties" will be the subject discussed by Harry Becker, M.D., chief of surgery at the General Hospital, Indianapolis, Ind., at a meeting of the Second Councilor District at the Henderson Country Club, Henderson, on July 2.

Wives are invited to attend the meeting, which is scheduled to begin at 6:30 p.m. Robert English, M.D., Henderson, is in charge of arrangements.

Announcement of the meeting was made by Walter L. O'Nan, M.D., councilor for the Second District.

Dr. Pedigo Appointed to Board of Ky. Chamber of Commerce



George W. Pedigo, Jr., M.D., Louisville, recently became the first physician ever to be appointed to the Board of Directors of the Kentucky Chamber of Commerce.

Doctor Pedigo is associate editor of the Journal, vice speaker of the House, and was recently elected president-elect of the Jefferson County Medical Society.

Commenting on Doctor Pedigo's appointment, Chamber president, Thomas A. Ballantine, Louisville, said, "It is with a great deal of pleasure that we welcome Doctor Pedigo as a member of our Board. I am sure his presence on our Board will contribute greatly to its success. His willingness to serve is evidence that physicians are becoming more aware that their help is needed to correct the civic and economic ills of the community."

KSMA president R. W. Robertson, M.D., Paducah, expressed his delight with Doctor Pedigo's appointment to the Board. He said it was most important for physicians to participate in activities designed to promote the civic and economic climate of business and industry and that this opportunity is amply afforded by working with the local and state chambers of commerce.

Luncheon for New Members Planned for Annual Meeting

All members that have joined the Kentucky State Medical Association since September 1, 1958, will be guests at a luncheon in their honor during the KSMA Annual Meeting on September 22-24.

Another feature of the KSMA's growing services to its members the luncheon will be held Tuesday, September 22 at the Brown Hotel. It has been scheduled so that it will not conflict with other events planned during the meeting.

N. L. Bosworth, M.D., chairman of the Committee on Public Information and Service, urged all new members to attend the luncheon. Invitations will be sent to all new members of record in the KSMA Headquarters.

Enforcement of Licensure Law May Affect "Nursing Homes"

A survey of all places in Kentucky presently classified as hospitals or convalescent or nursing homes has recently been completed by the State Department of Health, according to Paul A. Hackney, director, Division of Hospital and Medical Facilities. Administration of the Hospital Licensure Law has been assigned to this division by the State Board of Health—the official licensing agency.

Effective July 1, the Hospital Licensure Law will be fully enforced, according to Mr. Hackney, and some places which formerly called themselves nursing or convalescent homes will now be classified as personal care homes.

A revised regulation by the State Board of Health says that these homes that do not qualify for classification under the Hospital Licensure Act, may no longer use the terms "convalescent or nursing homes" in their titles. A letter has been written to all homes which, as a result of the survey, have not been put in the convalescent or nursing home classification.

Only hospitals or convalescent or nursing homes which have a medical type program, adequate patient or medical records and proper nursing personnel may be classified under the Act. Others will come under the category of "personal care homes" and will still be inspected by appropriate divisions of the State Department of Health, but will not be licensed as "hospitals." Mr. Hackney said, "The difference between the "personal care home" and the nursing or convalescent home is one of personnel and service." The survey was conducted in 120 counties ending in Jefferson County the last of May.

KAGP Honors Drs. Witten and Allen at Annual Assembly in April

The youngest "Family Doctor of the Year" ever to be chosen by the Kentucky Academy of General Practice—Carroll L. Witten, M.D., Louisville, received the award during the KAGP's annual assembly in Louisville on April 22-24.

Doctor Witten, who was recently elected vice-speaker of the American Academy of General Practice's Congress of Delegates is 35. A graduate of the University of Louisville School of Medicine in 1951, Doctor Witten was founder and first editor of the Journal of the Jefferson County Medical Society. For six years he has been a delegate to the KSMA House of Delegates and twice chairman of the Jefferson County delegation.

Annual achievement award of the Academy went to George S. Allen, M.D., Louisville, for the second time. This year's honor was for "classroom" instruction given by Doctor Allen to expectant mothers.

John G. Archer, M.D., a former KSMA councilor for the 14th District, is president-elect of the Academy. Doctor Archer will succeed Daryl P. Harvey, M.D., Glasgow, vice chairman of the national committee of the White House Conference on Children and Youth to be held in Washington in 1960, as president next year.

Charles G. Bryant, M.D., Louisville, preceded Doctor Harvey as president. Edgar B. Morgan, M.D.,



Officers of two Kentucky surgical groups got together following elections at a joint meeting of the Kentucky Surgical Society and the Kentucky and Indiana Chapters of the American College of Surgeons at French Lick in May. From left to right are—William T. Rumage, Jr., M.D., Louisville, secretary of the Kentucky Chapter, American College of Surgeons; Branham B. Baughman, M.D., Frankfort, president of the Kentucky Surgical Society; E. C. Strode, M.D., Lexington, president of the Kentucky Chapter, American College of Surgeons; and C. Melvin Bernhard, M.D., Louisville, secretary-treasurer of the Kentucky Surgical Society.

Louisville, was elected vice president; John J. Rolf, M.D., Covington, secretary-treasurer; Doctor Witten, delegate to the AAGP; and C. Walker Air, M.D., Ludlow, alternate delegate.

Chosen directors were: Guinn S. Cost, M.D., Hopkinsville; Carlisle V. Dodson, M.D., Russellville; Melvin J. Weber, M.D., Ludlow; Robert W. Fidler, M.D., Flemingsburg; and E. C. Seeley, M.D., London.

Dr. Strode Heads Ky. Chapt. Am. Coll. of Surgeons

The Kentucky Chapter of the American College of Surgeons elected chapter secretary E. C. Strode, M.D., Lexington, president for 1959-60 during a joint meeting with the Indiana Chapter and the Kentucky Surgical Society at French Lick, Ind., in May.

Doctor Strode succeeds James C. Drye, M.D., Louisville, as president. William T. Rumage, M.D., was elected secretary of the Society.

Plans to meet next year either late in April or early in May were made and the Kentucky Chapter extended an invitation to the Indiana Chapter to meet jointly with them at French Lick. The Kentucky group will be hosts at the 1960 meeting.

Dr. Baughman Chosen to Lead Ky. Surgical Society

Branham B. Baughman, M.D., Frankfort, former KSMA councilor for the 7th District, was elected president of the Kentucky Surgical Society at French Lick on May 15-16, during a joint meeting with the Kentucky and Indiana Chapters of the American College of Surgeons. He succeeds H. Hart Hagan, M.D., Louisville, as president.

James E. Hix, M.D., Owensboro, was elected vice president and C. Melvin Bernhard, M.D., Louisville, was re-elected secretary-treasurer. Francis M. Massie, M.D., Lexington, shared the spotlight with John Mason Brown during the Society's dinner. Doctor Massie gave a presentation on the progress being made at the McDowell Home.

Four new members were elected to the Society, which limits its membership to 125, at the meeting. They include: Harold E. Kleinert, M.D., Louisville; Dixon R. McCloy, M.D., Bowling Green; J. Marvin Keeton, M.D., Ashland; and Sam D. Weakley, Jr., M.D., Louisville. Next year's meeting is scheduled for May 14 at French Lick.

U of L Woman Graduate Elected to Lead Texas Assoc.

May Owens, M.D., a graduate of the University of Louisville School of Medicine in 1921, has been chosen president-elect of the Texas Medical Association.

When she assumes the presidency in 1960, Doctor Owen will be the first woman to hold office in the Association's 106-year history.

Chairman of the scientific council for the past nine years, she was the first woman to be president of the Tarrant Medical Society, and is past president of the Texas Society of Pathologists.

Open Council Meeting is July 30

Garnett J. Sweeney, M.D., Liberty, has announced that the annual open meeting of the KSMA Council will be on Thursday, June 30, in Louisville at the South Room of the Brown Hotel. Any member wishing to attend is welcome to do so, Doctor Sweeney said.



ANNOUNCING

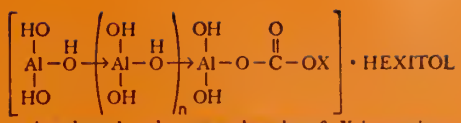
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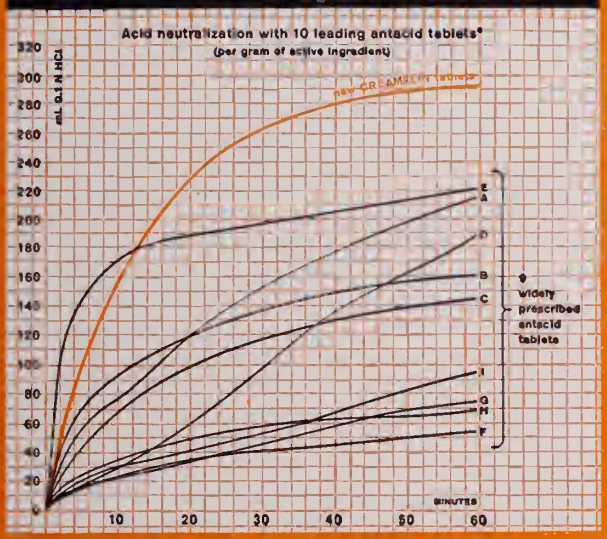
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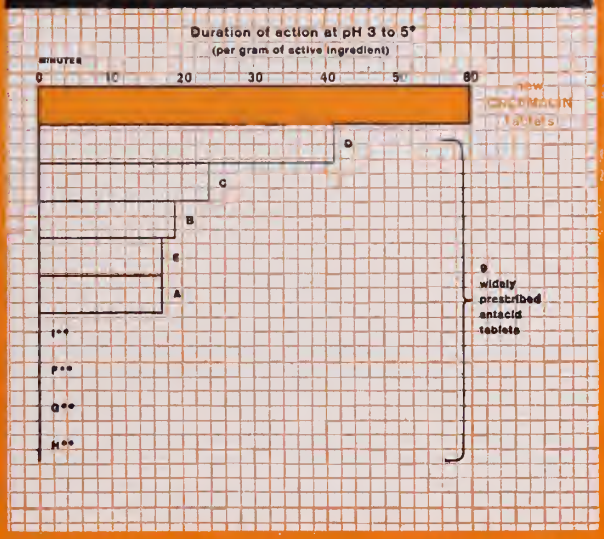
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Digest of the Minutes of the April 2 Meeting of the KSMA Council

Garnett J. Sweeney, M.D., Liberty, chairman, called the day-long meeting of the Council to order in Louisville on Thursday, April 2. Minutes of the December 11, 1958 meeting were adopted.

The President reported that he had attended the County Society Officers Conference, a special meeting of the House of Delegates, a conference on Third Party Medicine, and had spoken at Senior Day and at the Ninth Councilor District meeting.

The Headquarters Office report was presented by the Secretary. The report showed that the Senior Class at the University of Louisville School of Medicine was very grateful for the Association's efforts at Senior Day. It was stated that 151 had registered for the County Society Officers Conference in Lexington. Among other activities, the Headquarters Office was promoting meetings for eight Councilor Districts.

Legislative Affairs

The Council was informed that Thomas B. Leonard, M.D., Frankfort, has resigned as chairman of the Legislative Committee and that his resignation had been accepted by the Executive Committee with regrets. Wyatt Norvell, M.D., New Castle, was elected to serve as temporary chairman of the Legislative Committee for State Affairs, with Doctor Leonard serving as temporary vice-chairman.

Gaithel L. Simpson, M.D., chairman of the KSMA Committee on Medical Education and Economics, was recognized and explained that as directed by the 1958 House of Delegates his committee had prepared a proposed bill for indigent medical care. After the proposed bill was explained, it was approved by the Council with the understanding that it would be sent to the Allied Council on Medical Services for further consideration prior to its presentation to the Legislature.

The Council voted to defer taking a poll on the subject of compulsory Social Security for physicians. After discussion it adopted a recommendation of the Committee on Scientific Assembly and Arrangements that a $50 honorarium be paid guest speakers participating in the scientific program of the Annual Meeting.

Walter S. Coe, M.D., Louisville, chairman of the KSMA Committee on Postgraduate Medical Education, reported on the activities of his committee. It was agreed that the money set aside in the budget for this committee's use would be made available when a definite plan is submitted by the committee to the Council and is accepted.

Ralph D. Lynn, M.D., Elkton, chairman of the Budget Committee of the Council, explained the 1959-60 proposal which was unanimously accepted by the Council.

**As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the minutes of the April 2 meeting of the Council of the KSMA.*

Problems of the Aged

After the seven recommendations of the Committee on Problems of the Aged were considered by the Council, the Headquarters Office was authorized to send copies of the recommendation to all county medical societies and all hospital staff secretaries. It was the feeling of the Council that the seven-point program would stimulate activity at the local level in meeting the problems of the aged.

The Council authorized Woodford B. Troutman, M.D., Louisville, secretary of the KSMA, to determine whether or not the Association should support the forming of a new joint council to improve the health care of the aged at the state level or to recommend that the Council on Allied Medical Services take over this function in addition to the other activities it carries on.

New Journal Cover

George W. Pedigo, M.D., Louisville, associate editor of the Journal of the KSMA, presented a proposal for a new cover for the Journal. The recommendation which was made by the Editor and his Advisory Committee was accepted by the Council. Following the report on the Southeastern Editors Conference, Doctor Pedigo was authorized to explore the possibilities and costs of holding the 1960 Conference in Louisville.

Following a report by Delmas M. Clardy, M.D., Hopkinsville, chairman of the KSMA Advisory Committee on Public Health, the council voted to:

1. Recommend compulsory vaccination for diphtheria, pertussis, tetanus, and polio for all children prior to entrance in grade school.

2. Offer the Department of Public Safety in Frankfort the KSMA's assistance in combatting the tragic loss of lives in highway accidents.

3. Give publicity, in the interest of public health, to the facilities available for detection of cancer of the cervix.

4. Officially endorse fluoridation in Kentucky.

5. Take no action on the question of cigarette smoking and its relation to lung cancer.

6. Follow the practice of the U. S. and Kentucky Public Health Departments in the use of BCG vaccine, inasmuch as it is of a controversial nature.

Health Council

Carl Cooper, M.D., Bedford, reported for the committee that had been appointed to work with the proposed Kentucky Health Council. A proposed amendment to the Health Council by-laws offered by Doctor Cooper was approved by the Council.

Doctor Cooper also brought the recommendations of the Committee on Public Information and Service of which he is a member. The recommendation that KSMA sponsor a luncheon for new members on Tuesday of the Annual Meeting was accepted. The Council authorized the Committee to carry out the program it had proposed for the dissemination of

information on Third Party Medicine. In addition, the Council, after discussion, established the procedure for the release of news items to the press on activities of KSMA Committees.

Russell E. Teague, M.D., Commissioner of Health, reported that the State Board was considering the possibility of modifying the Medical Practice Act in Kentucky so that certain foreign physicians approved by the Educational Council for Foreign Medical Graduates might be licensed. He also said that consideration was being given to amending the Medical Practice Act, making it mandatory that an annual registration of all physicians be carried out. The registration fee would be two dollars per physician.

Open Meeting

The Chairman of the Council explained that it was customary for the Council to have an open meeting each year, and July 30 was set as the date for the 1959 open meeting. It was decided to have the 1960 County Society Officers Conference on Thursday, April 7, at Owensboro, Kentucky. The 1962 Annual Meeting to be held in Louisville was scheduled for September 18, 19, 20.

After lengthy discussion, the Council requested the KSMA Advisory Commission to Blue Shield to work with the Blue Shield staff to bring forward a proposed plan for providing coverage on a full-payment plan for the people of Kentucky. The Commission was asked to be in a position to report by July 30.

To strengthen the machinery for arbitration of grievances, the Council decided to form a grievance committee for each councilor district. The chairman of the Council was authorized to appoint as chairman of each district the councilor for that district with two councilors from adjoining districts making up the balance.

Student AMA Members Attend Meet in Chicago

Five members of the University of Louisville Medical School student body attended the ninth annual Student AMA Convention in Chicago on April 30-May 3, according to Olson Huff, delegate to the Student AMA's House of Delegates.

Attending the meeting with Mr. Huff were: Barney Elliott, alternate delegate, James Smith, Bill Collis, and Ed Landis. Highlighting the program were presentations by Alton Ochsner, M.D., New Orleans, and Corbett Thigpin, M.D., co-author of the "Three Faces of Eve." Scientific presentations and student scientific exhibits were also part of the program.

William R. Kirkham, Oklahoma, was elected national president: E. H. Lamkin, Indiana, vice president; and Emil Pollard, Michigan, treasurer. Expenses for the representatives were paid by the KSMA and the local SAMA Chapter.

Big Spring Golf Club Site of 1959 Golf Tourney

Big Spring Golf Club in Louisville, site of the 1952 National PGA Tournament, will be the scene of the 1959 Kentucky State Medical Golf Association Tournament on September 22, 23, and 24, according to Lanier Lukins, M.D., Louisville, chairman of the golf committee.

Doctor Lukins said all members of the KSMA would be contacted in the near future and that an application blank will be inserted in the August issue of the Journal.

Permanent trophies, plus one year's possession of traveling trophies, will be awarded to those winning in the low gross, low net, and senior championship categories. Daily prizes will be awarded to low gross and low net winners. Last KSMGA tournament held at Big Spring was four years ago in 1955.

Dr. Monroe Chosen to Head Ky. Ob-Gyn Group

Robert F. Monroe, M.D., chairman of the KSMA Committee on Infant and Maternal Mortality, was elected president of the Kentucky Obstetrical and Gynecological Society at Kentucky Dam Village on May 7-9.

He succeeds Erwin G. Heiselman, M.D., Newport, as president. Other officers elected at the three-day meeting were John Seal, M.D., Covington, vice president, and Douglas Haynes, M.D., Louisville, secretary-treasurer.

Principal speaker at the meeting was C. Paul Hodgkinson, M.D., gynecologist-obstetrician-in-chief at Henry Ford Hospital in Detroit. Guest speaker at the banquet on May 8 was T. S. Waller, Paducah attorney.

Nat'l Group Elects McPheeters

Harold McPheeters, M.D., Kentucky Commission of mental health, has been elected secretary-treasurer of the newly formed National Association of State Mental Health Program Directors. Purpose of the group is to draw up some guidelines across the country so that there's some definite blue print for mental health.

Doctor McPheeters was secretary of a committee that drew up a constitution and bylaws after an initial meeting last fall. Election of officers took place on May 1. Other officers are: George Jackson, M.D., mental-health director of Kansas, president; and Clifton Perkins, M.D., Maryland mental health commissioner, vice president.

Nursing Home Group Elects in Lexington

The Kentucky Association of Nursing Homes two-day meeting in Lexington on April 29-30 was attended by about 60 "nursing homes" operators, according to Mrs. Ann Stokes Ralph, Association secretary. Mrs. Elizabeth Baxter, Louisville, was elected president to succeed Miss Lillie Goodrich, Lexington.

Other officers elected at the meeting were Jamie Miller, Lexington, first vice president; Pauline Clift, Princeton, 2nd vice president; Robert Hansen, Eminence, 3rd vice president; Mrs. Ralph, secretary; Bernice Sisk, Madisonville, treasurer; and Mrs. Baxter, governing council.

Purpose of the Association, which has approxi-



Photo courtesy of Lexington Herald-Leader

Pictured at the meeting of the Fayette County Medical Society on May 12 are—(left to right) W. O. Preston, Lexington, president of the county society; guest speaker Robert S. Sparkman, M.D., Dallas, Tex.; and Escum L. Moore, M.D., Lexington.

mately 57 members, is to work for upgrading of care for the convalescent and the aged. Mr. Ira Wallace, New Castle, past president of the Kentucky group, is a delegate to the American Association of Nursing Homes and immediate past president of that group.

Nurses Defeat Somerset M.D.'s

A near capacity crowd witnessed the second annual Doctor-Nurses basketball game in Somerset which the nurses won by two points. Held to raise money to send a deserving local girl through the nursing school of her choice, this year's venture raised about $300 for the Nurses' Scholarship Fund.

Several well-known stars for the Green Monsters, as the medicos were known, were reported recuperating following the loss. One suffered bruised ribs during the game, another was hobbling on a swollen right ankle and another reportedly was having trouble getting out of bed the following day. Leslie Langley, M.D., was voted as the most-liked opponent by the nurses—the White Satellites—for his habit of stopping to apologize when he inadvertently stepped on a nurse's foot.

Dr. Love to Go to Indianapolis

Jesshill Love, M.D., director of radiotherapy and of the cancer clinic at St. Joseph's Infirmary in Louisville, is scheduled to move to Indianapolis about July 1. He will become professor of radiology and chief of the section on radiotherapy at the Indiana University Medical Center.

Doctor Love will also help organize a cancer clinic for teaching medical students and residents and for coordinating all types of medical and surgical procedures for cancer patients. A graduate of the U of L School of Medicine in 1929, who has always practiced in Louisville, he is assistant clinical professor of radiology there and was recently named president-elect of the American Radium Society. His positions at St. Joseph will be taken over by Wesley G. Farnsley, M.D., Louisville.

KAGP Plans Big Sandy Seminar

The annual Big Sandy Seminar of the Kentucky Academy of General Practice is scheduled for July 16 at the Paintsville Country Club in Paintsville.

Chairman will be James W. Archer, M.D., Paintsville. Full details on the meeting were not available at press time and will appear in the July issue of the Journal.

Mental Health Grants Awarded

Kentucky institutions are included in a list of institutions in 22 states and Canada which have received mental health in-service training grants since June, 1958. Grants have been awarded to enable employees of mental hospitals and training schools in the Southern region to study care and treatment in institutions anywhere in the country.

Nine grants have been awarded in Kentucky. Hospitals having recipients of grants include: Central State Hospital, Lakeland; Eastern State Hospital, Lexington; Kentucky State Hospital, Danville; and Western State Hospital, Hopkinsville.

Applications for grants are being accepted until June, 1960. Inquiries should be addressed to Paul W. Penningroth, M.D., Southern Regional Education Board, 130 Sixth St., N. W., Atlanta 13, Ga.

Fayette Meeting Attended by 250

More than 250 attended the annual dinner meeting of the Fayette County Medical Society at the Lexington Country Club on May 12, according to William O. Preston, M.D., president of the Society.

Featured speaker was Robert S. Sparkman, M.D., Dallas, Texas. Secretary of the Fayette County Medical Society is Matthew C. Darnell, Jr., M.D.

Dr. McLeod Heads Pediatricians

Robert McLeod, M.D., Somerset, was elected president of the Kentucky Pediatric Society at the group's 10th annual meeting at the Lafayette Hotel in Lexington on April 9. Elected vice president was Robert Rice, M.D., Richmond, and secretary-treasurer Leslie Langley, M.D., Somerset. Doctor McLeod succeeds Caroline Scott, M.D., Lexington. Principle speaker at the meeting was Josef Warkany, M.D., professor of research pediatrics at the University of Cincinnati.

Thirteen Added to KSMA Roster

New additions to the KSMA membership roster are:

Robert H. Berry, M.D., Ft. Thomas
Robert F. Breashear, M.D., Winchester
Edwin Cameron, M.D., Louisville
Royce E. Dawson, M.D., Owensboro
Thomas Harrison, M.D., Brownsville
Samuel McCreadie, M.D., Louisville
William A. McManus, M.D., Owensboro
Harold Moberly, M.D., Winchester
James E. Monin, M.D., Jamestown
Thomas G. Perkins, M.D., Paris
Richard Teder, M.D., Paris
Harold Tuch, M.D., Covington
Edwin H. West, M.D., Louisville

Committee Reports

Committee on Rural Health

Mitchell B. Denham, M.D., Chairman

Louisville **April 22**

Plans to hold the seventh Kentucky Rural Health Conference in Bowling Green in November were formulated by the committee.

The committee voted to recommend the Bowling Green site and the November date to the Kentucky Rural Health Council. Decision was made to move the conference site from Louisville, where the conference has been held in the past, since it was felt that another location would be of greater value to rural Kentuckians.

Although the Conference would be for the entire state, the committee recommended that in 1960 particular emphasis be placed on promoting attendance from Todd, Logan, Simpson, Allen, Monroe, Adair, Metcalfe, Barren, Green, Hart, Edmonson, Butler, and Warren counties.

Other items discussed at the meeting concerned farm safety and the possibility of writing health articles for farm journals.

KSMA Advisory Commission to Blue Shield

W. Vinson Pierce, M.D., Chairman

Louisville **April 30**

Seventeen of its 21 members attended the Commission's first meeting and gave lengthy consideration to the problems of providing low cost coverage of the aged and full payment coverage.

The first subject had been reviewed previously by the Commission's Executive Committee. After further study, the Blue Shield staff was directed to re-study the proposal to include broader coverage, and report back at a later date.

The request of the KSMA Council that the Commission develop and present to the Council a full coverage or service type contract was considered at length. The staff of Blue Shield was asked to develop a full payment plan proposal, taking into consideration the relative value approach, for presentation at the time the Senior Citizen's policy is considered.

Committee to Study Constitution and By-laws

Cooley L. Combs, M.D., Chairman

Lexington **May 7**

The committee's second session of the Associational year devoted five and one-half hours to working on the proposed revamping of the committee structure, membership, and organizational matters of the Association.

A substantial portion of the time was devoted to the matter of committee structure. The 1957 House of Delegates directed the committee to make this study. The committee made a progress report to the 1958 House of Delegates—requesting permission to revise the committee structure so that it would be patterned very much like that of the AMA. This proposal was accepted by the House.

The committee has scheduled a third meeting of the year for June 25, in which it hopes to perfect its report to the House of Delegates. KSMA staff and legal counsel are working under committee supervision on this report.

Committee on School Health

Carroll L. Witten, M.D., Chairman

Louisville **May 7**

Plans to sponsor Kentucky's first conference on athletic injuries were made by the committee. The Conference will be held at the Memorial Coliseum in Lexington on August 12th, the opening day of the annual Coaches' Clinic at the University of Kentucky.

The Conference will have prominent physicians, coaches, trainers, and athletes on the program to discuss such subjects as injuries to the head and brain, muscular-skeletal injuries, internal injuries and responsibilities of those involved in athletic programs.

Preliminary plans are already underway to invite all coaches in Kentucky to the conference and to have the Kentucky High School Athletic Association and the State's Advisory School Health Council cooperate with the KSMA in the Conference. All physicians are invited and urged to attend.

Committee on Infant and Maternal Mortality

Robert Monroe, M.D., Chairman

Kentucky Dam Village **May 8**

The committee met at Kentucky Dam Village in conjunction with the annual meeting of the Kentucky Obstetrical and Gynecological Society reported on page 721.

A panel presented by the Committee constituted a portion of the Ky. Ob-Gyn group program. The panel demonstrated to the group the workings of the committee—placing special emphasis on the manner in which cases were presented to respect the complete anonymity of the physician who handled the case.

The panel was in the form of a sample meeting of the committee.

6th District Meet Attended by 80

About 80 physicians, nurses, and visitors attended the joint meeting of the KSMA's Sixth Councilor District and the Sixth District of the Tuberculosis Hospital in Glasgow on April 21.

Featured speaker was Michael L. Furcolow, M.D., U.S. Public Health Service, Kansas City, Kan. Other comments were made by C. C. Howard, M.D., Glasgow, and John P. Glenn, M.D., councilor for the KSMA's Sixth Councilor District. Waller H. Griffing, M.D., is secretary of the Sixth District.

Application

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1959 Annual Meeting — Kentucky State Medical Association

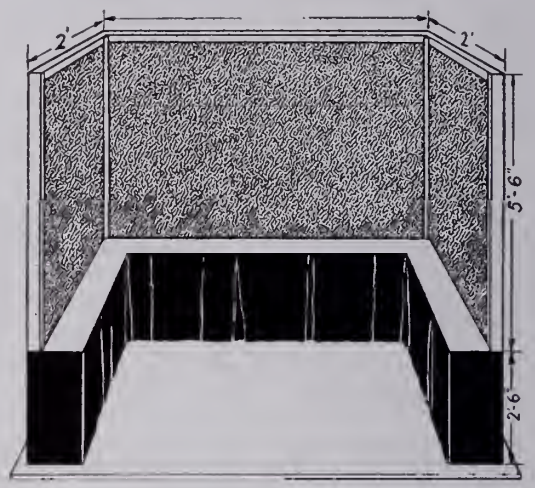
Columbia Auditorium — Louisville, Kentucky — September 22, 23, 24

Fill Out and Mail to:

EVERETT L. PIRKEY, M.D., Chairman
Committee on Scientific Exhibits
Louisville General Hospital,
Louisville 2, Kentucky

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2. Description or nature of exhibit: (Attach brief description to this blank).

3. Will you require shelf space? .....

4. Give approximate amount of wall space needed. (Included in total space is two side walls of two feet in length) .....

5. Name of institution co-operating in the exhibit (if desired) .....

6. Name of exhibitor: .....

..... (Street & No.) ..... (City)

The Kentucky State Medical Association will provide without cost to the exhibitor the following: Exhibit space, shelves, sign for booth, current, bracket lights, provided all items are approved in advance by the committee.

Cost of transporting exhibits to the meeting must be borne by the individual exhibitor as well as costs of cards, signs, etc., which are a part of the exhibit.

View boxes, furniture, decorations, etc., may be rented, if desired, by applying directly to Jos. T. Griffin Company, 704 West Main Street, Louisville 2, who supply equipment for the annual K.S.M.A. meeting.



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In Memoriam

J. J. BAKER, M.D.
Cutshin
1895-1959

J. J. Baker, M.D., died at the age of 86 at the home of his son in Cutshin on April 8. He had practiced in Cutshin for about 60 years.

A native of Cutshin, he had lived there all of his life. Doctor Baker was a graduate of the Lincoln Memorial Hospital in Knoxville, Tennessee.

ROBERT L. IRELAND, M.D.
Louisville
1873-1959

R. L. Ireland, M.D., who practiced surgery in Louisville for 58 years, died at his home on May 8 at the age of 86.

Doctor Ireland, who retired from active practice in 1952, was on the medical staffs of Norton Memorial Infirmary, Kentucky Baptist Hospital and was staff physician for Baptist Theological Seminary for many years. He was an 1894 graduate of the old Kentucky School of Medicine.

HARVEY C. BLANTON, M.D.
Richmond
1911-1959

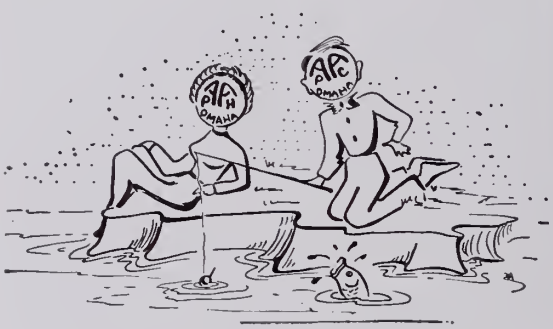
Harvey C. Blanton, M.D., Richmond, died in his sleep at his home in Richmond on April 19. He had been ill for several years.

A native of Madison County, he had practiced in Madison since completing his internship training, with the exception of five years when he served with the U. S. Army Medical Corps. During World War II he served in the Pacific theater. Doctor Blanton graduated from the University of Louisville School of Medicine in 1936 and interned at Charity Hospital, New Orleans, La.

DEWEY H. REPS, M.D.
Louisville
1896-1959

Dewey H. Reps, M.D., assistant medical director at E. I. du Pont de Nemours and Company's neoprene plant in Louisville, died of cancer at St. Joseph Infirmary on April 11.

Doctor Reps graduated from the University of Cincinnati College of Medicine in 1925. He had been assistant medical director at the plant in Louisville since 1950.



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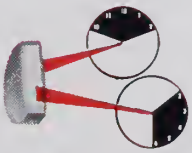
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References: 1. Sheldon, J. M.: Postgrad. Med. **14**:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy **19**:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly **37**:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. **112**:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. **5**:1183 (Sept.) 1958.

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In Memoriam

(Continued from Page 726)

SIMEON SMITH AMERSON, M.D.
Georgetown
1868-1959

Simeon Smith Amerson, M.D., retired Georgetown physician, died on May 2 at Central Baptist Hospital in Lexington at the age of 90.

He had practiced in Scott County from 1920 until his retirement in 1953 and before that he had practiced in Union County for more than 20 years. Doctor Amerson was a graduate of the University of Nashville Medical Department in 1896.

J. C. HARTMAN, M.D.
Campbellsburg
1885-1959

J. C. Hartman, M.D., 74, Campbellsburg, died on May 6 at Kings Daughters Hospital in Shelbyville after an illness of eight weeks. He was a 1908 graduate of the University of Louisville School of Medicine.

Doctor Hartman had practiced at Minorsville, Turners Station, and Sulphur and for the past 36 years had been practicing in and around Campbellsburg. He had practiced medicine for about 50 years.

Psychiatrists Elect Dr. Ackerly

Spafford Ackerly, M.D., Louisville, was elected vice-president of the American Psychiatric Association—largest psychiatric society in the world—at the 115th annual meeting of the Association in Philadelphia recently. Doctor Ackerly is professor and chairman of mental health at the University of Louisville School of Medicine and medical director of the Louisville Child Guidance Clinic sponsored by the Community Chest.

Dr. Eller to Move to Missouri

C. Howe Eller, M.D., chairman of the department of community health at the University of Louisville Medical School, will become health commissioner of St. Louis County, Missouri, about July 1.

Doctor Eller was health director of Louisville and Jefferson County from 1949 to 1955. St. Louis County contains the city of St. Louis, but Doctor Eller's post will cover only the county outside the city. He will also be professor of public health at Washington University Medical School in St. Louis.

Nurses Rates Raised in May

Members of the Jefferson County Nurses Registry, a group of private-duty registered and practical nurses, raised their rates May 1. Fees for 8-hour shifts went from $14 to $16 a day for registered nurses and from $10 to $12 a day. The last previous rate increase was in November, 1955.

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R. CHARMAN CARROLL, M.D.
Medical Director

ROBERT L. CRAIG, M.D.
Associate Medical Director

JOHN D. PATTON, M.D.
Clinical Director

Maternal Mortality Page

(Continued from Page 670)

The medico-legal aspects of postmortem cesarean section have never been established by any court decision. Of course if the procedure is performed with the permission of the husband, there can be no legal problem. It should be remembered when we assume the care of a pregnant woman we accept the responsibility for two lives, both the mother and the infant. If through some overt omission to act, as refusal to respond to a call, the mother should die, we are liable for breach of contract. The courts' attitude toward the unborn infant is variable and beset with various so called "fictions" and the reaction is unpredictable. It would seem unlikely that a court would decide against a physician who tried to protect the right of the unborn child by postmortem cesarean section. But there is no precedent.

One other practical point might be stressed. One should not be discouraged from attempting this procedure if the fetal heart is heard. Cases are recorded in which a living infant was delivered from a mother who had expired some 20 minutes before.

NEWS ITEMS

H. A. Perry, M.D., a graduate of the University of Louisville School of Medicine in 1957, is now in the general practice of medicine in Stearns. He interned at Louisville General Hospital.

Geraldine Paxton, M.D., was recently appointed director of communicable-disease control for the Louisville-Jefferson County Health Department. Formerly in private practice in Louisville, she succeeds Dorothy Magallon, M.D., who is now with the State Department of Health.

Mary Pauline Fox, M.D., has taken the position of County Health Physician for Bell and Knox Counties. She was formerly associated with Edward Wilson, Jr., Pineville, in the general practice of medicine. Her appointment was effective May 1.

Hampden C. Lawson, M.D., and his wife were hospitalized briefly after a head-on automobile crash on April 18. Doctor Lawson is chairman of the physiology department of the University of Louisville School of Medicine. They were driving home from a medical meeting in Atlantic City, when their car collided with another, half a mile west of Florence, Ky.

William E. Davis, M.D., North Middletown, recently became health officer of Harrison, Scott, and Bourbon counties. For the past 20 years, Doctor Davis has practiced in Bourbon County. Before that for 10 years he served the Christian Church as a medical missionary in the Belgian Congo. A series of articles he wrote for the Saturday Evening Post were later published in a book entitled, "Ten Years in the Congo." Doctor Davis received his M.D. degree from Northwestern University in Chicago in 1927.

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1 hospital bed and mattress
1 padded treatment table
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1 bassinet, pad, and stand
1 swivel chair

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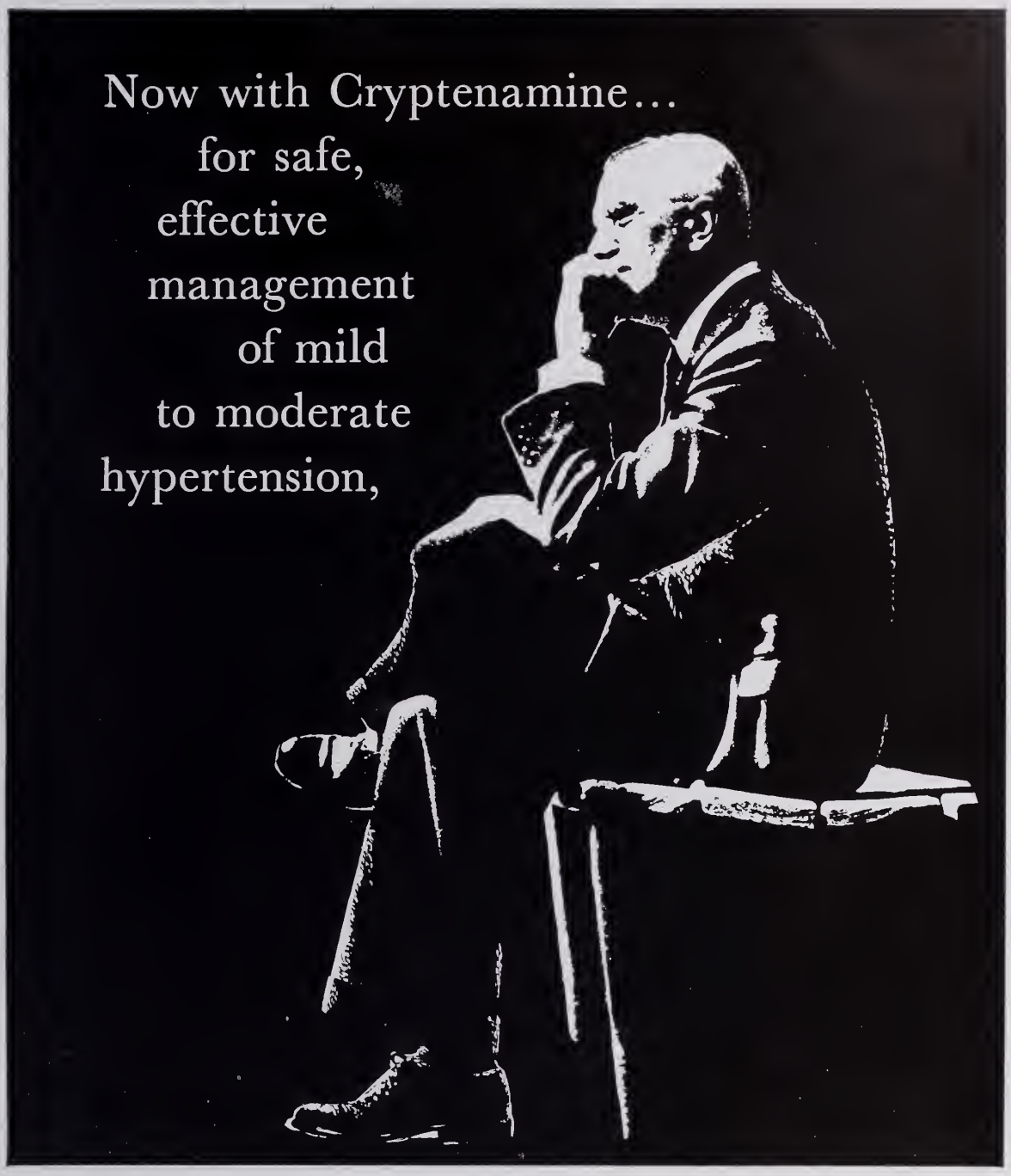
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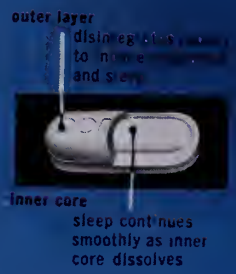
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1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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Hary Hineman, M.D., Indianapolis, Director of the Actuarial Division of the Indiana Blue Cross-Blue Shield, spoke toa bout 40 physicians at a meeting of the First Councilor District in Paducah on April 22.

J. Vernon Pace, M.D., Paducah, is councilor for the 1st District. Host group at the meeting was the McCracken County Medical Society of which Walker Turner, M.D., is president.

Nurses League Elects Miss Metz

Miss Mildred Metz, director of nursing education at Norton Memorial Infirmary, Louisville, was elected president of the Kentucky League for Nurses at the league's three-day convention at Mammoth Cave in April. Advances in nursing pediatric surgical patients was discussed by B. J. Schoo, M.D., Louisville.

Robt. McKechnie Heads SAMA

Robert K. McKechnie, Louisville, was elected president of the University of Louisville Chapter of the Student American Medical Association at a meeting in Louisville on May 12. A junior, he succeeds Neville Caudill, Louisville, this year's president.

Elected vice president was Charles Gross, Frankfort, a sophomore; Olson Hoff, a freshman, was elected secretary-treasurer. They will serve in 1959-60. As president, McKechnie will write the Student AMA column which appears in the Journal from October through May.

Practical Nurses Meet in April

More than 260 attended the 11th annual convention of the Kentucky State Association of Licensed Practical Nurses in Louisville on April 23-25. Among featured speakers at the meeting was James C. Drye, M.D., Louisville who spoke at the banquet at which new officers were installed.

Mrs. Goldie Waskey, Russell, is president of the group. Her term expired next year. Newly elected officers include: Mrs. Elizabeth Jenkins, Lyndon, first vice president; Mrs. Elizabeth Satchel, Lexington, treasurer; Mrs. Mary Cox, Lexington, assistant treasurer; and Mrs. Mary Begley, Lexington, and Mrs. Eugene LeSieur, Harlan, directors.

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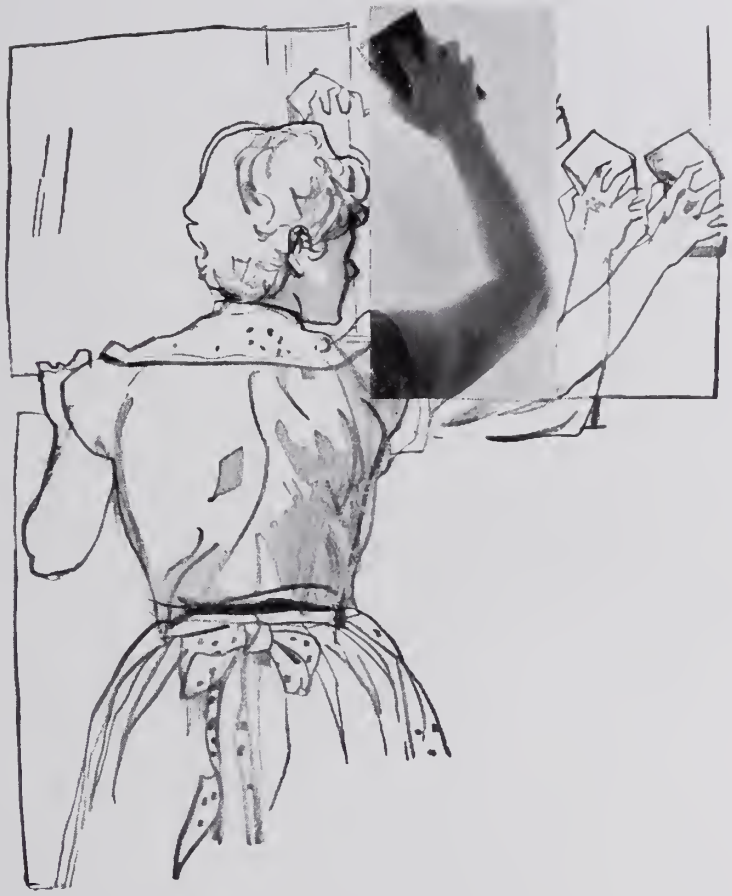
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Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

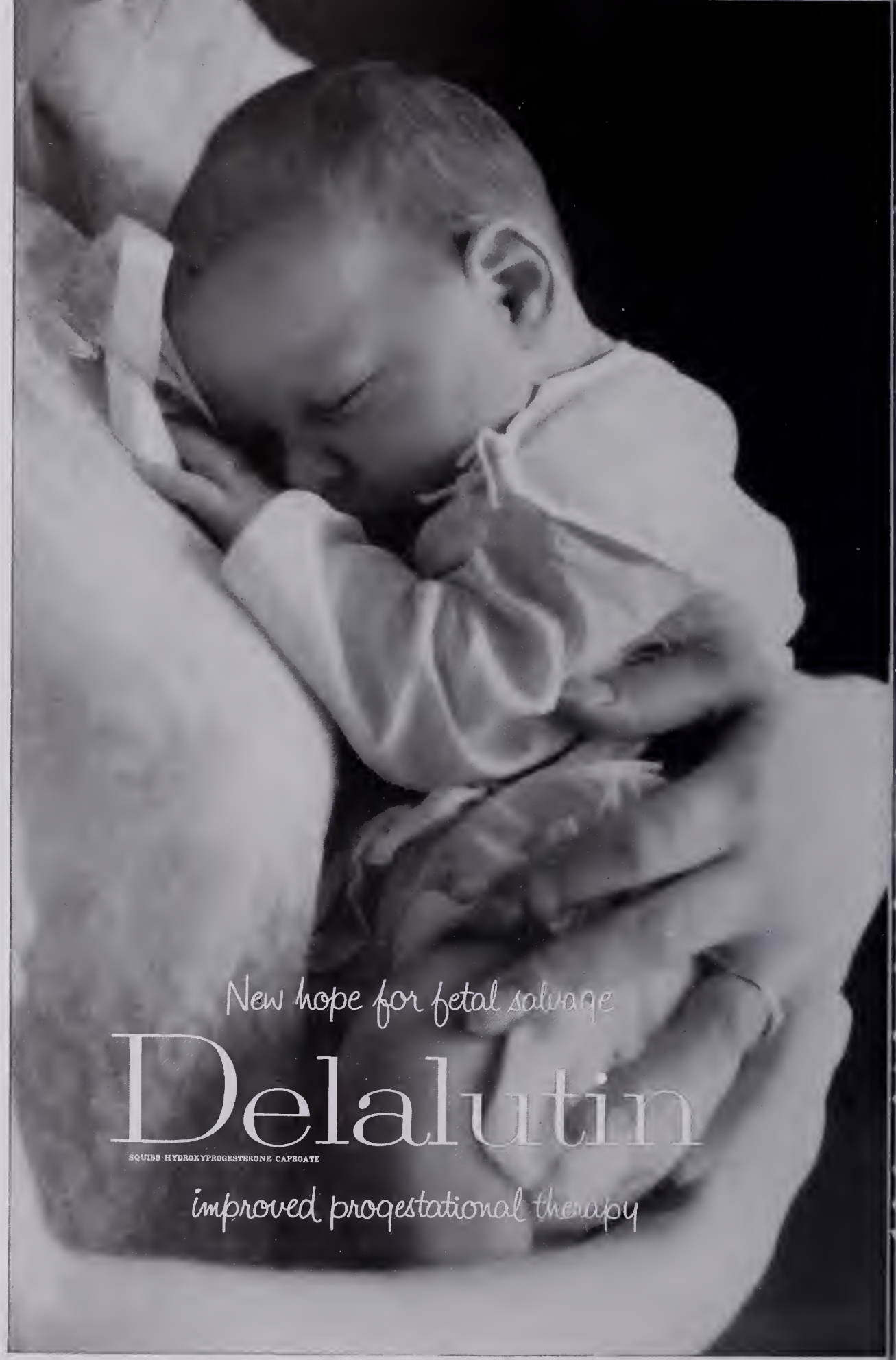
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Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
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Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
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A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

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- longer-acting and more sustained therapy
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DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

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Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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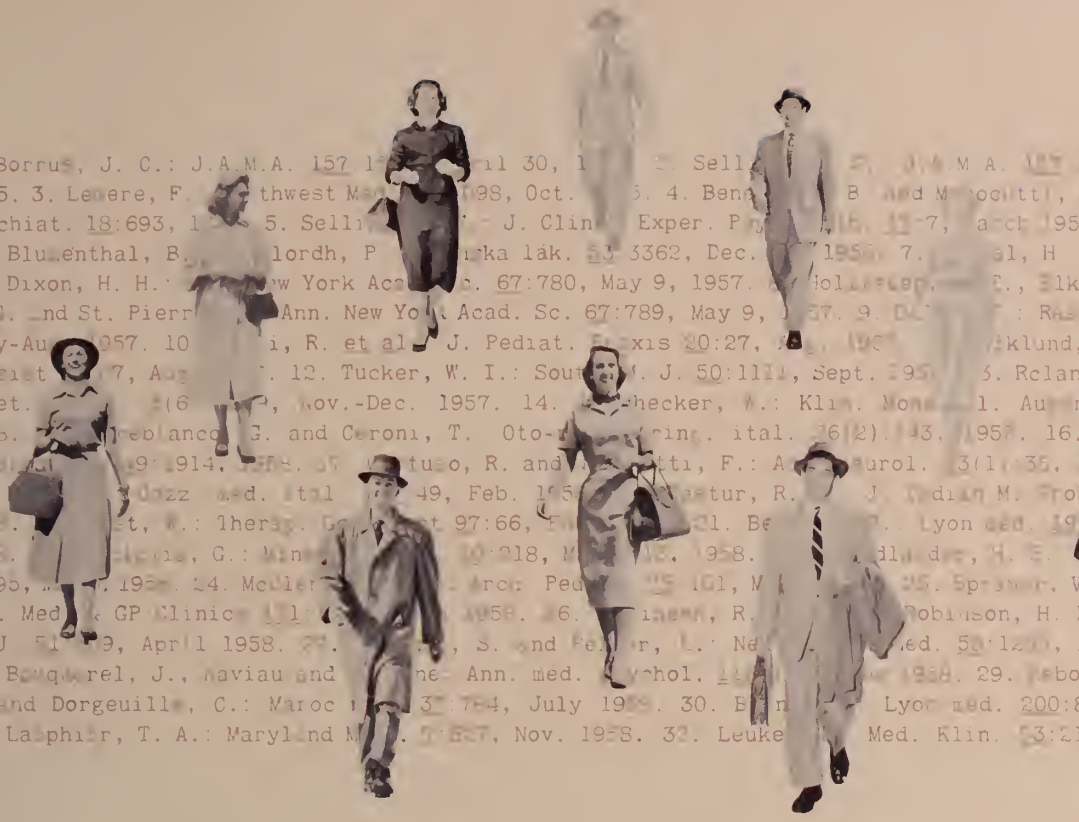
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PUBLIC HEALTH PAGE

Health Statistics — Vital, Valid or Void

RUSSELL E. TEAGUE, M.D.

Commissioner of Health, Commonwealth of Kentucky

AS might well be imagined, the Department of Health is occasionally confronted with a question as to the real value of health statistics. It is not difficult at all to understand why a physician might say, "The information you are receiving on death certificates and morbidity reports cannot possibly be very accurate," or, "After all, when so few post mortem examinations are carried out, one can't expect to obtain effective cause-of-death information," or, "You people in Public Health require too specific explanations on reporting causes of death. Many times, the best information we have for the cause of death is simply 'heart attack,' and that ought to be good enough."

The Vital Statistics office in many localities has proved to be, for many physicians, a vast "record room" where they have been able to obtain community-wide information for epidemiologic research in such wide areas as Tay-Sachs disease or leukemia, etc. Few physicians are really familiar with health statistics procedures in a health department activity. It is apparent that this lack of knowledge is reflected in the inaccurate use of such certificates without due regard for such influences as certification habits of physicians, the concept of a single cause of death, management of nosology problems, and the international classification system used. It seems profitable, therefore, to review some of these factors and to assess their part in determining the meaning of health statistics.

Obviously, the process starts with the recording of the cause of death or morbidity record by the attending physician, and it is a truism that health statistics can reflect no more than is originally reported. If it is assumed, for the moment, that the physician has thoughtfully and clearly reported his best clinical judgment regarding the conditions that lead to death or sickness, and any significant pathology contributing, what then comes out of the statistics, how does it get there, and, are some manipulations necessary at times?

Probably the most important factor involved in cause-of-death reporting is the primary cause of death which is defined as *that condition-or-injury (or circumstances of the injury) that initiated the train of morbid events leading directly to the death.* The question arises, then, as to which of the several existing conditions caused the death. The clinician may logically say that none of the conditions singly in a specific patient, but rather the complex of conditions, caused the death. But for numerous good reasons, the classification does not provide for combination of diseases in most instances. This is largely due to the fact that preventive medical programs have traditionally sought information regarding the initiating factor in the disease sequence leading to death, in order that efforts toward prevention might be placed at the origin of the process.

As a matter of more specific explanation, it is important to note that the cause-of-death section on the death certificate provides for medical certification in two parts. In the first part (Part I) the physician is asked to state a single condition (for example, scarlet fever), or a pathological or etiological related sequence, or conditions with the most recent manifestation stated first (for example, septsicemia due to gangrene due to diabetes). Part II of the medical certification allows for the reporting of other significant conditions but not directly related to the disease named in Part I.

As one might well suspect, despite the ease of correct reporting, in many instances it will be necessary to resort to rules for selection of the underlying cause. The physician may report a related sequence in apparently reverse order, or he may record clearly unrelated conditions in Part I (for example, diabetes due to stangulated inguinal hernia). The nosologist at the health department has only two courses open: to query the physician, who is acutely annoyed by this, or to decide the issue in some systematic way. Unless the physician is asked to clarify his intent in this instance, the death will be charged to diabetes on the reason that the physician must have considered the disease more important since he stated it first and that, hence, he really meant to report the inguinal hernia in Part II.

In many states, such facts as period of gestation, weight at birth, complications of pregnancy, and operative intervention are ascertained on the birth certificate for each delivery, and in some areas even more factors are investigated. This trend has already led to the appointment, by the Kentucky State Medi-

(Continued on Page 748)

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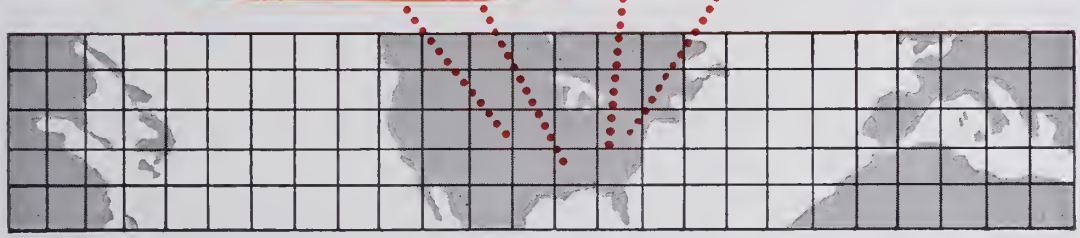
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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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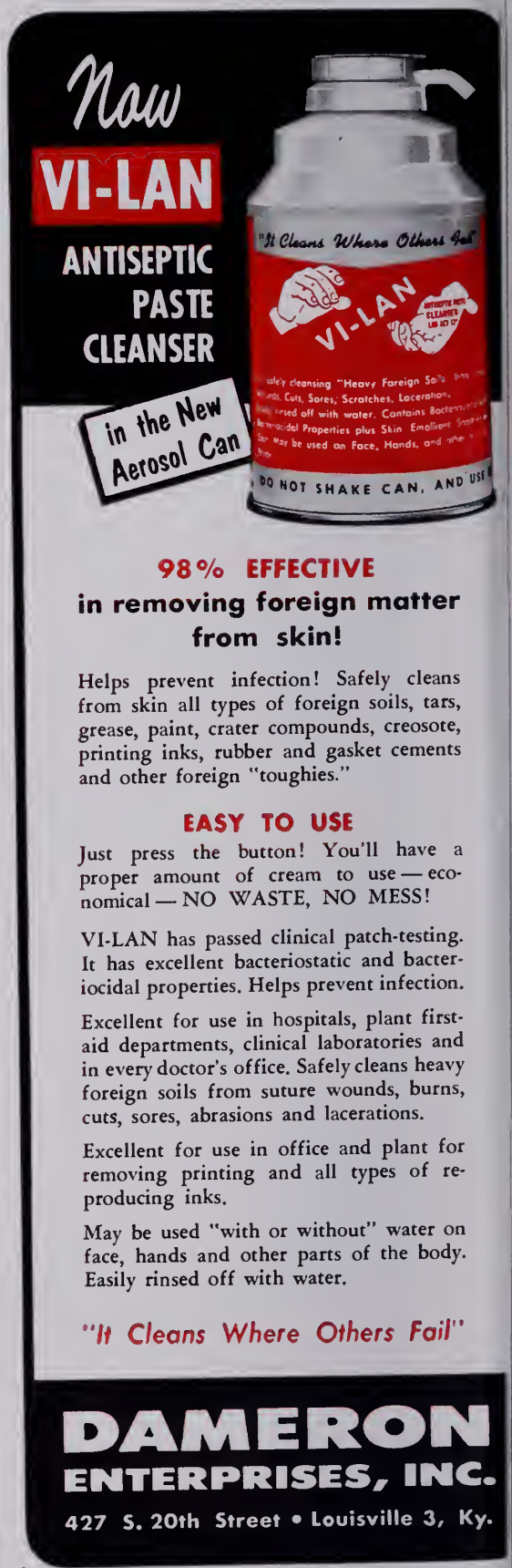
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cal Association, of a committee for the study of maternal and perinatal mortality. It has become quite apparent that more effective use must be made of fetal loss data and new patterns of analyzing causes of death are needed, perhaps in conjunction with other facts related to pregnancy and delivery. Here again, the collection of such data imposes an obligation not alone to use the data intelligently for program guidance and research leads, but also to evaluate them—and much more attention must be given in the future to this phase of the problem. It must be made clear, too, that analysis of mass records need not be equated with clinical research; each approach has a well-defined scope and purpose.

Much is made of the discrepancies often noted between clinical and autopsy diagnosis. Moreover, many physicians would disagree as to the specific cause reported and others feel that they really do not know the specific cause. Although such discrepancies are significant for individual patients, studies indicate that the volume of relatively correct reporting minimizes this error to the point that it does not materially affect the mass data. Furthermore, we cannot expect mortality statistics to be better than diagnostic ability; the physician can relate no more in describing the cause of death than he knew in treating the patient.

In considering the justification for health statistics, the need of patient or the citizen is undoubtedly the most important issue involved. A certified copy of birth or death is frequently necessary, and, many times required quite promptly for legal purposes. Other major uses of health statistics are physicians, not only in public health, but research clinicians, pathologists, and practicing physicians with special interests. The attending physician, therefore, in completing the health statistics records, is fundamentally transmitting information to his colleagues. His respect for them and related reports, which will probably be published, should be adequate incentive to do the best possible job.

In conclusion, it can be said that mortality and morbidity statistics have many useful purposes. They are admittedly, limited by their nature, and, of course, no more can be expected of them than they are capable of producing. Continuous efforts are being made to improve the accuracy and usefulness of health statistics. Physicians are encouraged to report to their best clinical judgment, the most appropriate cause of death for tabulating purposes by the arrangement of the medical certification form. Many prominent and effective groups, local, state and national, are continuously seeking methods of improving their tabulations. Fundamentally, the reporting physician determines the validity of available data and his careful attention to this major role will aid his community and his colleagues.



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References: 1. Finkelstein, M., et al.: J. Pharmacol. & Exper. Therap. 125:330 (April) 1959. 2. McHardy, G., et al.: Postgrad. Med., in press. 3. Winkelstein, A.: Amer. J. Gastroenterol., in press. 4. Finkelstein, M., et al.: Presented at Fall Meeting, Amer. Soc. Pharmacol. & Exper. Therap., 1958. 5. Leming, B.: Clin. Med. 6:423 (March) 1959.

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THE INSURANCE PAGE



IN this issue of the Journal of the Kentucky State Medical Association we have the privilege of introducing a new feature, "The Insurance Page." The idea of having such a column was conceived by the editor and his advisory committee, and its establishment was authorized at a recent meeting of the council of the K.S.M.A. It is hoped that this page can provide a service to the readers of the Journal by keeping them informed about the efforts which are being made to cope with the problems of health care through the use of insurance and prepayment plans.

More than one-hundred-twenty million people in the United States today have some form of prepaid protection against hospital expense; over one-hundred-nine million have some protection against surgical expense, and over seventy-two million are protected, at least in part, against medical care costs other than surgery.

The use of prepayment arrangements and of the installment principle to meet the costs of living have become an accepted part of the American way of life. To a great extent, this accounts for the phenomenal growth of prepaid health insurance plans. Most people today find it both convenient and necessary to budget the costs of their health care, just as they budget the costs of owning their autos and their homes.

Prevent Socialized Medicine

As physicians we should be grateful for the fact that development of the voluntary health insurance plans have gone far toward preventing the establishment of a system of compulsory prepaid health insurance, or some even more unpalatable form of socialized medicine.

We must also bear in mind the fact that these voluntary health care plans have enabled a large number of our people to preserve their personal dignity and independence by paying their own way; rather than by having to call on welfare and public assistance agencies to provide them with medical care. This, in turn, has taken a great burden from the taxpayers by reducing the amount of charity services to be paid from public funds. Let us also recognize that we physicians receive a considerable proportion of our personal income, today, from the payment of insurance claims for services rendered to our patients.

There are many types of prepaid health insurance, and many mechanisms for providing the care. Some plans are better than others, obviously, both in the adequacy of coverage, and in regard to the effect of the plans on the "doctor—patient" relationship. Some plans, such as Blue Shield and Blue Cross, are sponsored by medical societies, and are organized on a non-profit basis. Plans offered by commercial insurance companies also render a valuable service to their subscribers, even though the profit motivation of necessity played some role in their development. Consumer sponsored plans, such as those developed by some of the larger labor unions, may take the form of closed panel systems.

Cooperation Needed

While some of us may dislike the idea of the insurance companies or the Blue organizations participating in the provision of medical care; and even though we may resent the increasing amount of time and work involved in filling out insurance papers; it behooves us to cooperate in every legitimate and reasonable manner with all ethical health care plans, and to have at least a working understanding of the principles and methods of operation of these plans. For us to fail to do so, will render much easier the task of the "do-gooders" who wish to see a paternalistic government assume the function of furnishing all health care for our people.

It shall be the purpose of this column to attempt to provide from month to month, informative material concerning various aspects of health insurance. Members of the Board of Directors of Kentucky Physicians Mutual, and of the KSMA Advisory Commission to Blue Shield, will be asked to contribute to the discussions. The staff of our Blue Cross and Blue Shield plans, we are sure, will be generous with their advice and with factual data. Representatives of commercial insurance companies will be invited to express their viewpoints also.

Last, but not least, criticisms, suggestions and questions from the readers of this page will be sincerely welcomed.

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(1) Ernst, E. M., and Snyder, A. M.: Pennsylvania M. J. *61*:355, 1958.

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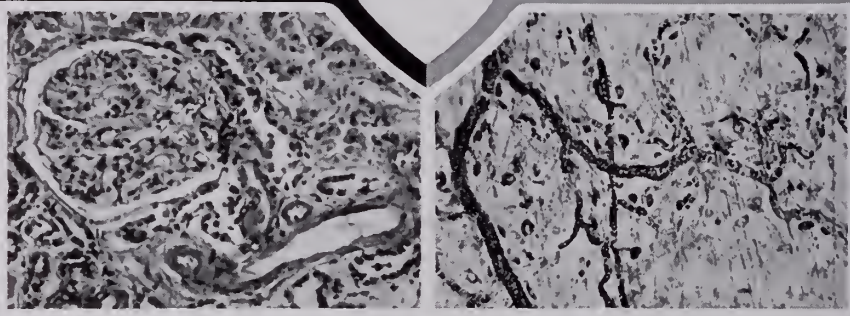
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References: 1. Moyer, J. H., and others: Am. J. Cardiol., 3:113 (Jan.) 1959. • 2. Bodi, T., and others: To be published, Am. J. Cardiol., (April) 1959. • 3. Fuchs, M., and others: Monographs on Therapy, 4:43 (April) 1959. • 4. Montero, A. C.; Rochelle, J. B., III, and Ford, R. V.: To be published. • 5. Rochelle, J. B., III; Montero, A. C., and Ford, R. V.: To be published.

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1. Editorial: New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med. & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

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WASHINGTON NEWS DIGEST

Washington, D. C.—Congress won the first round in a battle over medical research funds, but the Eisenhower Administration is in a strategic position for the final outcome.

The House voted $344,279,000 for the National Institutes of Health, $50 million more than the Administration asked for in the fiscal 1960 budget. The move to increase medical research funds also had strong support in the Senate.

However, the Health, Education and Welfare Department and the Budget Bureau will have the final say on how much of the appropriated funds are spent during the 1960 fiscal year when the Administration is striving to balance the budget.

Arthur S. Flemming, Secretary of Health, Education and Welfare, vigorously denied a charge of the Democratic-controlled House Appropriations Committee that the Administration had "gone so far as to set back the medical research program . . . in a desperate attempt to present, on paper, a balanced budget." Flemming said the committee was trying to give a "clearly misleading" impression. He also said it was hard to see how the Administration's $294 million program could be regarded as a backward step.

Flemming pointed out that the Administration request was for the same amount voted by Congress last year. And, he added, some of last year's appropriation will not be spent this fiscal year.

At the same time, U. S. Surgeon General Leroy E. Burney testified before a Senate Appropriations Subcommittee that there was a shortage of trained personnel in all fields related to human health, including medical research.

*** ***

Rep. Francis E. Dorn (R., N. Y.) again has introduced a bill that would provide for a special commission making a study of the supply of physicians. In a letter put in the Congressional Record, Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, envisaged an adequate supply on a long-range basis. He said: "Over the long haul, the increase in medical students is much greater proportionately than is the increase in the population . . . The future, I believe, looks

*** ***

A government-sponsored, six-year study of the causes of cerebral palsy, mental retardation and kindred defects in children has gotten underway in 16 private hospitals and universities.

The study involves no experimentation, only observation. About 40,000 women will be kept under close check from the second or third month of pregnancy through childbirth. Observation of their children will be maintained through six years of age.

*** ***

U. S. scientists have blamed Russia for most of the radioactive fall-out thrust into the atmosphere in the last two years. But testimony before a Joint Congressional Committee on Atomic Energy estimated that overall the United States and Great Britain had created nearly three times as much radioactive debris by testing nuclear weapons as the Soviet Union had.

Russian tests were described as "extremely dirty" as to radioactive debris. However, the Russians have not exploded as many test weapons and devices as the Western Powers have.

The scientists differed on the degree of danger to humans posed by the radioactive fall-out. John A. McCone, Chairman of the Atomic Energy Commission, said that up to now the fall-out hazard has been "very small" and not serious when compared with common hazards, including natural radiation. But he warned against a "very serious hazard" in the future if nuclear tests are not restricted by international agreement.

*** ***

The Walter Reed U. S. Army General Hospital in Northwest Washington quietly marked its fiftieth anniversary recently. Its 448,000 patients since it was founded in 1909 have included presidents, congressmen, cabinet members and other notables. President Eisenhower underwent an ileitis operation there in 1956. Gen. John P. Pershing died there in 1948 after being a patient for seven years. The two most distinguished patients recently: former Secretaries of State John Foster Dulles and George C. Marshall.

*** ***

A Food and Drug Administration official has urged that physicians use care and judgment in writing PRN and similar prescriptions for sleeping pills and amphetamines. Nevis Cook of the agency's enforcement bureau said some pharmacists have been selling the drugs too freely on such prescriptions. The FDA planned to take court action when a glaring abuse presented a strong case. The issue is whether a pharmacist improperly practices medicine by indiscriminately refilling such prescriptions.

*** ***

Navy and Public Health Service scientists reported that a commercially prepared vaccine proved 83 per cent effective in preventing Asian flu in a study among naval recruits at the Great Lakes Naval Training Station. U. S. Surgeon General Leroy E. Burney said the controlled survey confirmed previous observations that "good protection results" from inoculation with the epidemic, Asian-strain vaccine.

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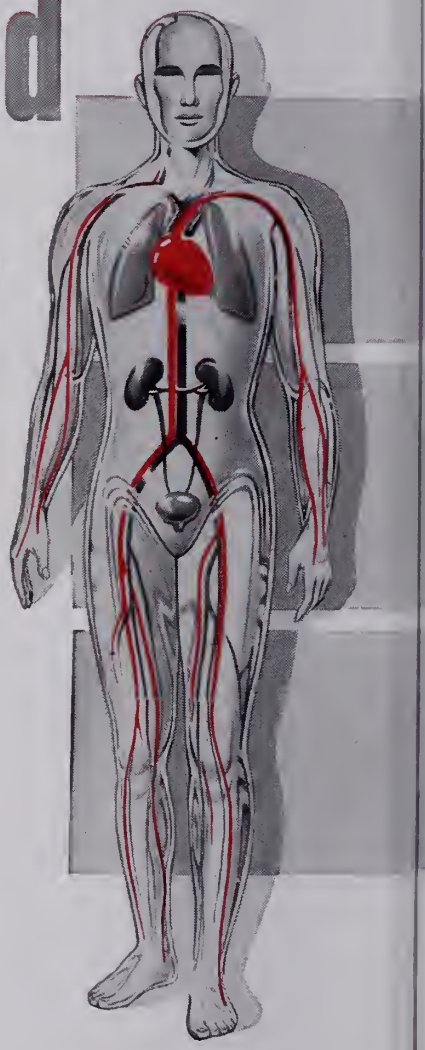
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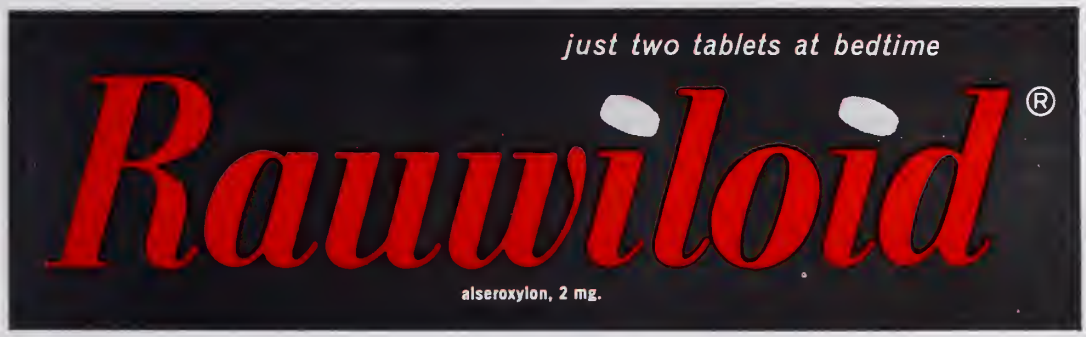
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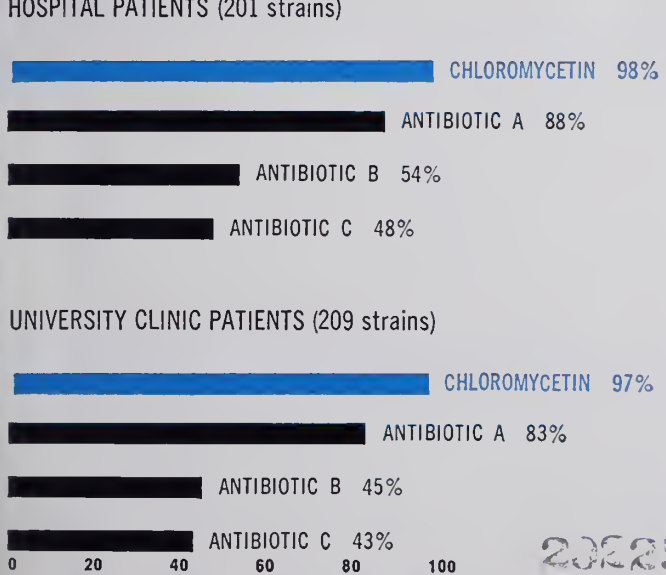
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*Adapted from Fischer.[8]

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JOURNAL of the KENTUCKY STATE MEDICAL ASSOCIATION

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message from the President

As the Psalmist David wrote, "The days of our years are three score and ten; and if by reason of strength they be four score years, yet is their strength, labour and sorrow—so teach us to number our days, that we may apply our hearts unto wisdom."

AS the years gradually slip by we think of those years when we can not maintain the fast pace we are now setting. As time marches on as inevitably as the sun rises, we must realize that tomorrow's years bring us into that group now so popularly called the Geriatric Age. Geriatrics, as I recall, was not stressed while I was in medical school or in my early years of practice.

For this reason it is very gratifying to see our profession at the state and national levels striving to do everything they can to help make those latter years of people; peaceful years with more abundant and longer lasting health. We have an active committee in geriatrics in our state medical association; and the American Medical Association is yearly having a seminar during one day of its meeting, with subjects entirely related to geriatrics.

One of our most eminent surgeons Warren Cole, M.D., professor of surgery at the University of Illinois, was chairman of this program which was well attended at our recent A.M.A. meeting. The information gathered at these meetings is of great benefit in helping many doctors both medically and surgically to understand the health problems of the geriatric age.

With the increasing number of old people in the population, accidents other than those caused by vehicles are assuming a greater importance, and we physicians should make every effort to educate our aging patients so that their later years are not marred by accidents.

I am happy to say that by constant observation of every small illness, my parents, both in their eighties, are active and enjoy life. I feel, in part, their long life and good health can be attributed to the great strides made in geriatrics. No doubt many of you who have parents of a corresponding age are of the same opinion.

This increase in knowledge has enabled many in their three score and four score years of life to say in the words of Robert Browning:

"Grow old along with me!
The best is yet to be,
The last of life for which the first was made:
Our times are in his hand
Who saith, 'A whole I planned,
Youth shows but half; trust God:
See all; nor be afraid!"

Robert W. Robertson



the disease of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

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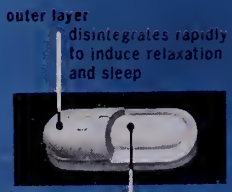
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1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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THE INSURANCE PAGE



Medical Coverage For The Aged

FEW actions of the House of Delegates of the American Medical Association in the past several years have received more favorable comment than the adoption of the policy that prepayment medical coverage shall be made available to people over 65 years of age, who have low incomes and modest resources.

At the same time, there has been some misunderstanding as to the intent and scope of this program, which has led to a certain degree of reluctance on the part of some members of our profession to endorse the idea.

The resolution which was approved by the House of Delegates on Dec. 4, 1958, reads as follows: *"For persons over 65 years of age with reduced incomes and very modest resources, it is necessary immediately to develop further the voluntary health insurance or prepayment plans in a way that would be acceptable both to the recipients and to the medical profession. The medical profession must continue to assert its leadership and responsibility for assuring adequate medical care for this group of our citizens.*

"Therefore, the Council on Medical services recommends to the House of Delegates the following proposal: That the American Medical Association, the constituent and component medical societies, as well as physicians everywhere expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources and low family income; that physicians agree to accept a level of compensation for medical services rendered to this group, which will permit the development of such insurance and prepayment plans at a reduced premium rate."

At the recent annual session of the AMA in Atlantic City, the Council on Medical Services submitted a progress report which showed that there has been a determined effort on the part of most of the constituent medical societies and the prepayment plans which they sponsor to comply with the recommendations of the parent body. There are now 21 Blue Shield plans in 19 states which have in operation programs for coverage of the aged. In 24 other areas the Blue Shield plans are working with their sponsoring societies to perfect and activate their programs. Our own plan, Kentucky Physicians Mutual, in cooperation with the Medical Advisory Commission to Blue Shield, expects to have its contract for the aged ready to submit to its Board of Directors and to the House of Delegates of the KSMA, for their consideration and approval, in the near future.

At a time when various strong pressure groups are clamoring for the passage of federal legislation to provide hospital and medical care for all of the recipients of social security benefits, physicians need to recognize that our best hope of forestalling such legislation is to demonstrate that the necessary coverage for the older age group can be provided on a voluntary prepaid basis. We should also realize that by making it possible for our senior citizens of low income to provide for their medical needs on a voluntary prepaid basis, we have helped them to preserve their dignity and independence.

Some of the misconceptions concerning this program may be corrected if the following pertinent facts are understood:

(1) The program is *not* intended to apply "across the board" to all persons above age 65. The group of older people for whom the insurance is intended includes only those to whom physicians would in most cases charge less than the usual fees; or, perhaps in many instances, no fees at all; in other words, for those with *reduced* incomes and *modest* resources, as has already been stated. The application of these terms is to be left to each medical society and its members.

(2) It is recognized that older people will require less of some services, such as obstetrics and some of the specialized surgical services than will the younger age groups; but that they will require more medical services, and that the programs will need to be "tailored" to allow for this difference.

(3) It must be stressed that this is an experimental or pilot program at this time, and that subsequent modifications will be indicated as our experience increases. It is hoped that in the future an increasing number of persons who have had prepaid protection during their active years will be able to carry this protection over into their retirement years. This should bring about a decrease in the need for a special program for the aged.

Space does not permit a more detailed discussion of the program at this time, but it is planned that in future issues of the Journal such discussion will be forthcoming; especially as concerns the program now being developed by our own Blue Shield Plan.

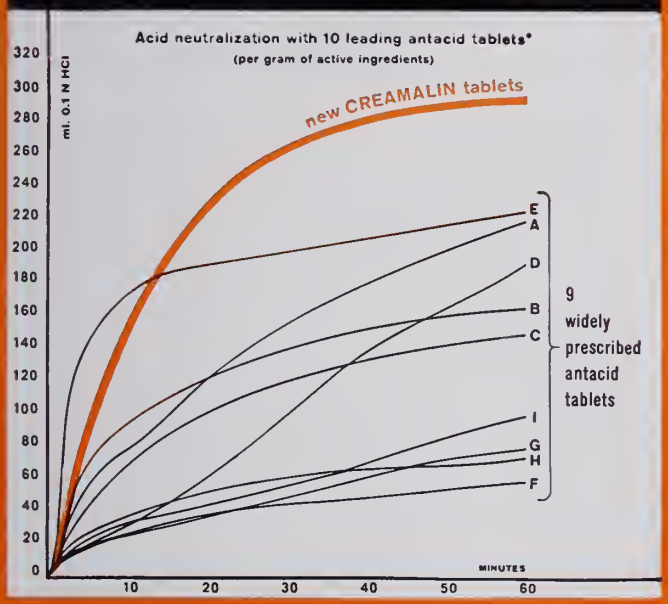
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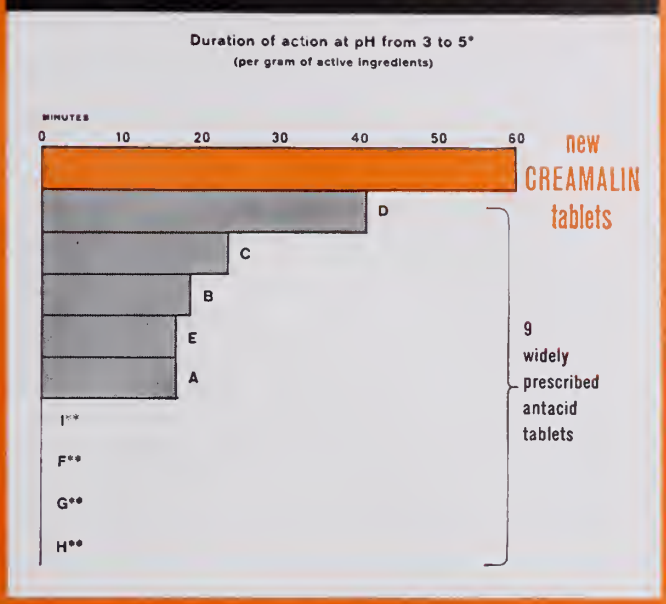
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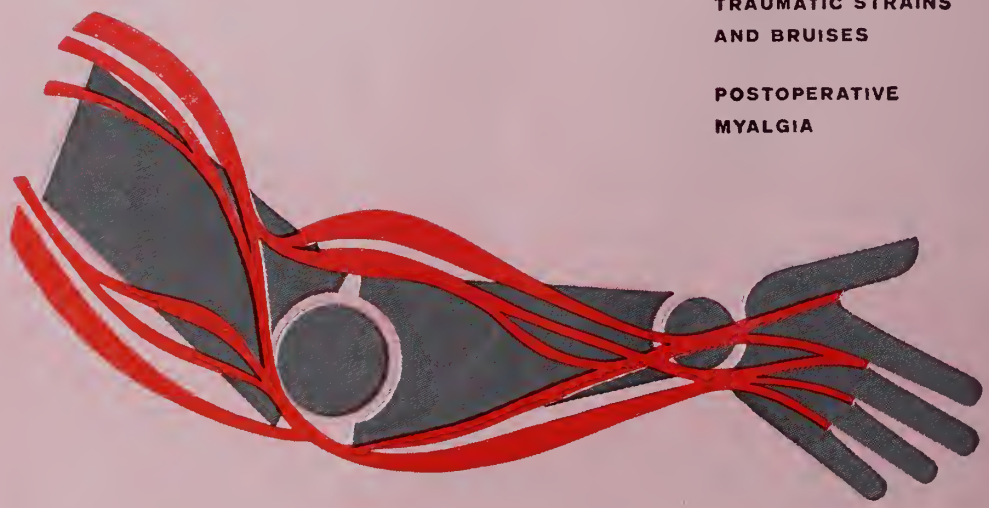
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WASHINGTON NEWS DIGEST

Washington, D. C.—Congress went into the final months of this session with a heavy workload of appropriate bills and foreign aid legislation to be acted upon before adjournment.

Congress must act upon the appropriate bills before adjournment to provide money for operation of the federal government during the 1960 fiscal year. Foreign-aid legislation also is generally put in the "must" category now.

With so much "must" legislation requiring action and Congress hoping to adjourn by late August or maybe earlier, many bills of varying importance will be left for further consideration next year.

An upsurge in the national economy strengthened the position of the Administration and economy-minded members of the House and Senate in their opposition to big-spending bills. Supporters of a Senate-approved $465 million airport bill conceded in advance that a House-Senate conference committee would approve a figure closer to the $297 million version which the House passed.

Substantial gains in industrial production, corporate profits, employment and other key economic factors raised Administration hopes for only a small deficit, if not a balanced budget, in the fiscal year 1960 which began July 1. There also was some talk in influential quarters of a possible tax cut next year. But at this stage, it was highly speculative. And it appeared most likely that if there is one, it will be small.

During the first five months of this session, Congress completed action on only two appropriation bills. They provided funds for operation of the Treasury and Post Office Department in fiscal 1960, and additional funds for various government activities during 1959.

Early in June, the House approved, 393 to 3, a $38,848,339,000 Defense Department appropriation which included $88.8 million for care of certain dependents of military personnel in civilian hospitals. In recommending the Medicare appropriation, the House Appropriations Committee commended the Defense Department "for its response to the intent of Congress . . . that dependents of military personnel have the benefit of prompt and adequate medical treatment at all times wherever they may be."

This contrasted with the Committee's criticism about two months ago. The Committee then expressed concern at what it termed "the high costs of care for military personnel and their dependents in civilian hospitals and the high fees allowed in the program."

In another Medicare development, the Surgeon General of the Army ruled (ODMC Letter No. 7-59) that a patient under the program who has suspected or proven malignancy is acutely ill and qualifies for care. The government will pay for urgently required treatment in such cases when certified by the attending physician.

But it was made clear that payment would be based "solely on the medical requirement for immediate hospitalization." Qualifications of urgency can not be based on mental anguish, emotional attitudes or socio-economic factors.

The Defense Department rejected two proposals of the Florida Medical Association for changes in the Medicare program. The Florida Medical Association proposed that a health insurance program be provided for dependents of military personnel or that control of the Medicare program be transferred to the Department of Health, Education and Welfare.

Dr. Frank B. Berry, Assistant Secretary of Defense for Health and Medicine,* said the present program could be handled best by the military service because military dependents "are a highly transient population."

* * * * * *

Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, suggested to the House Subcommittee on Administration of the Social Security Laws that it consider the advisability of a single Public Assistance medical program at the prerogative of individual states. There are now four such programs covering the blind, the aged, dependent children, and the permanently and totally disabled.

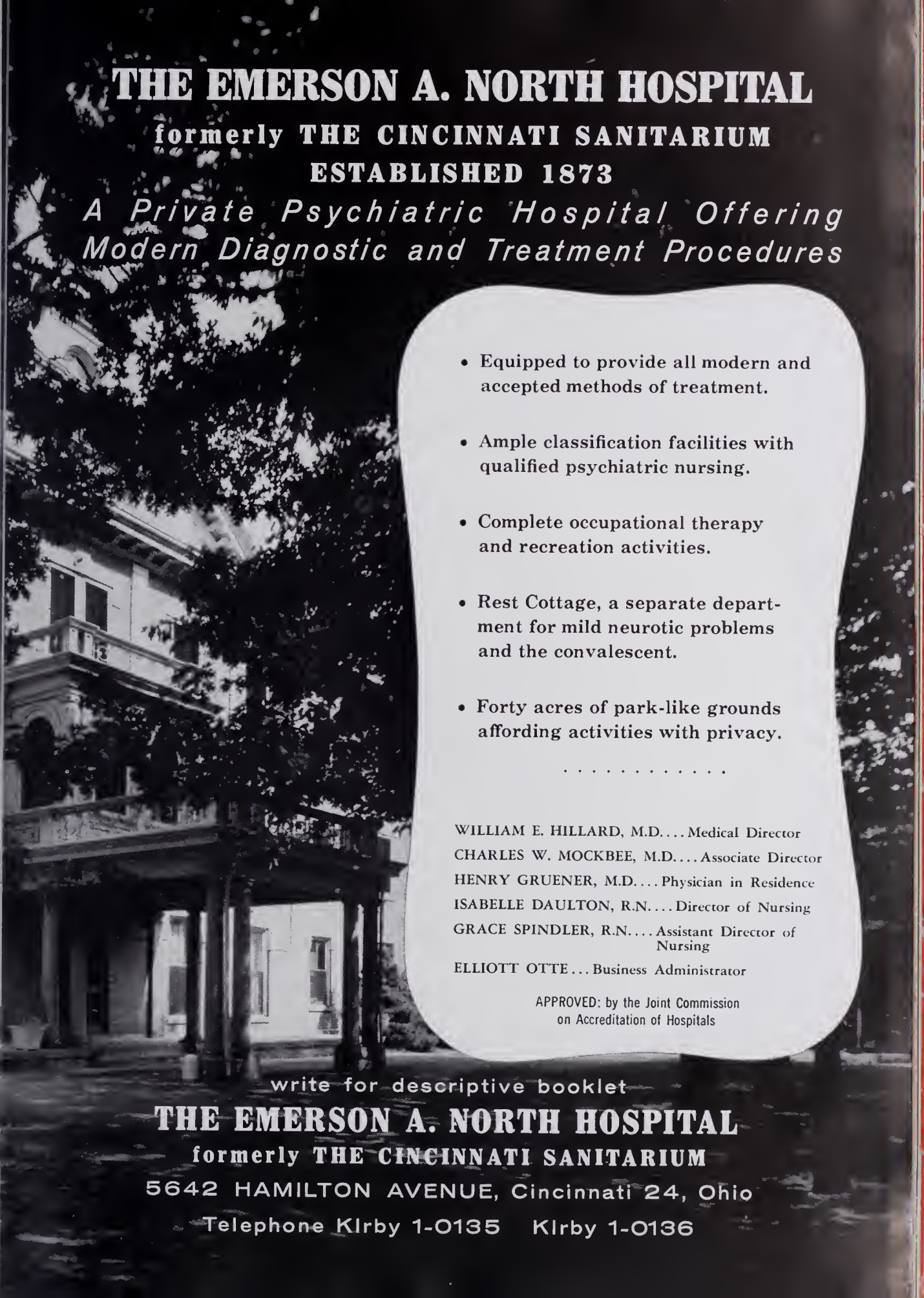
In a letter to Rep. Burr P. Harrison (D., Va.) Chairman of the Subcommittee, Dr. Blasingame also suggested consideration of:

Whether the medical staff of the Bureau of Public Assistance is now sufficient to provide adequate counselling to states on their individual programs, and

Whether "sufficient liason has maintained with the various professional organizations actually providing medical care.

Another suggestion of Dr. Blasingame was that a special medical advisory committee might be established in view of the fact that there are no physicians on the recently-appointed Social Security Advisory Committee.

**Dr. Berry will be President's Luncheon Speaker during the KSMA Annual Meeting.*



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3. La Barbera, J. F.: M. Rec. & Ann. *50*:242, 1956.
4. Bendig, A.: New York J. Med. *66*:2523, 1956.

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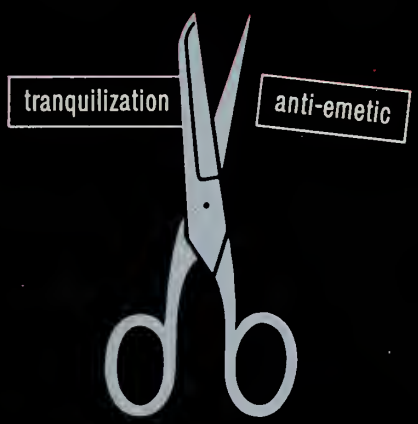
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Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

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- Parkinsonism
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"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

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remarkable lack of side effects

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"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."[5]

NO JAUNDICE

"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."[6]



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY "... produced extremely satisfactory results in the broad therapeutic range represented in this series."[3]

POTENT AGENT "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."[4]

MAJOR AODITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent.... It is effective in a variety of psychiatric disorders, including schizophrenic reactions.... The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."[6]

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."[7]

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life ... were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."[8]

"... extremely satisfactory results ..." in a clinical spectrum ranging from minor nervous disorders to severe psychotic disturbances[2]

RESULTS WITH MELLARIL IN 194 PATIENTS[2]

ACUTE PSYCHOTICS	CHRONIC PSYCHOTICS	NEUROTICS
83% satisfactory effect	68% satisfactory effect	57% satisfactory effect
Some cases had complete remission of symptoms. Most were able to return home to useful occupations	Relief of symptoms in cases permitted easier management and a return to a more or less useful life	Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

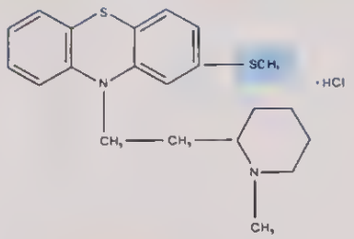
RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS[5]

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25

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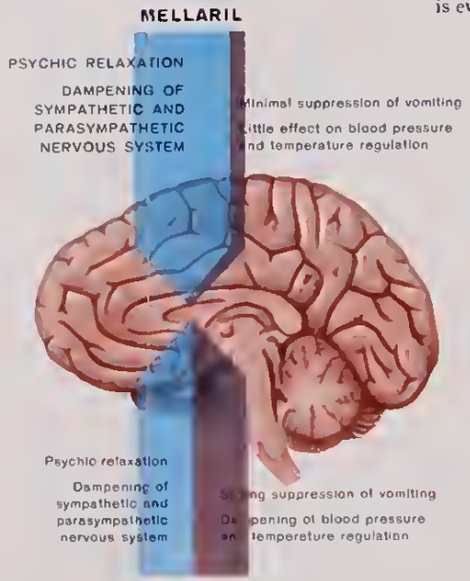
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tranquilization
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a new advance in tranquilization:
greater specificity of tranquilizing action plus fewer side effects



Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical ($S{\cdot}CH_3$) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



other phenothiazine-type tranquilizers



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD — where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE — where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

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1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959.

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

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2	Corticosterone is the only corticosteroid identified in adrenal venous blood.	☐	☐
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4	The pioneer experiments on the effects of adrenalectomy were performed by Addison.	☐	☐

For answers to quiz, see opposite page.

corticosteroid quiz

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answers: 1. False—by altering tissue reaction. 2. False—only hydrocortisone has been so identified. 3. True. 4. False—performed by Brown-Sequard.

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The Biopsy Of Breast Tumors*

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and DAVID W. KINNAIRD, M.D.†

Louisville, Ky.

Rationale

BY 1910, William Stewart Halsted, originator of the modern radical operation for the treatment of breast cancer, was able to say with assurance that one should never cut into a breast cancer for diagnostic purposes. It was always possible, in his experience, to make the diagnosis preoperatively by clinical examination of the breast. The material with which Halsted worked was composed almost entirely of Stage II and III cancers, the primary being of large size, with axillary involvement present in eight out of ten cases, and with an array of associated signs of malignant invasion, such as nipple retraction, "Peau d'orange," skin dimpling and fixation of the tumor mass, that facilitated clinical diagnosis.

Forty-eight years later, as the result of mass education of the laity on the subject of breast cancer, physicians are seeing patients with tiny, nondescript breast cancers measuring often less than 1.5 centimeters, too small and too recent to have developed the associated signs of malignancy which have been so diagnostically helpful in the past. These lesions are potentially highly curable provided prompt and proper treatment is administered.

To detect these early, minute cancers promptly requires surgical biopsy. Further, the philosophy of really early diagnosis requires that the physician accept the responsibility of having biopsies done on many small, perfectly benign breast nodules which can only be differentiated from the nondescript benign-appearing early breast cancer by this means. By the same token a philosophy that does not freely permit biopsy of innocent small breast lesions will automatically limit the cure rate of breast cancer to a figure little better than Halsted's time. This is true because, in the case of breast cancer, (1) Little knowledge has been added to the subject of the causative factors in breast cancer, (2) A precancerous lesion or condition in the breast lending itself to efficient prophylactic measures has not yet been established, and (3) Surgeons have reached the limit of effective physical extirpation of cancer with an acceptable mortality.

To delay biopsy until an innocent nodule has developed sufficiently to acquire clinically malignant characteristics means, in effect, a reduction in the chance of cure by more than 23 per cent.

*Presented at the Postgraduate Medical Seminar of the Norton Memorial Infirmary on December 18, 1958.

**Associate professor of surgery, University of Louisville School of Medicine.

†Instructor in surgery, University of Louisville School of Medicine.

Methods of Biopsy

In general, there are three methods of surgical biopsy of breast lesions. They are:

(1) Incisional

(2) Excisional

(3) Aspiration

Incisional.—By and large, incisional biopsy is preferable in the majority of cases. This means careful, atraumatic exposure of the lesion, and the gentle excision of a wafer slice of the mass. This may be followed by complete excision, if benign.

Excisional.—Careful exposure and wide excision *around* the mass, avoiding cutting into it or its capsule.

Aspiration.—A plug of tissue is extracted from the mass either with a large bore sharp needle and syringe, or by a type of trephine. Our objections to this method are:

(1) It is traumatizing.

(2) It is difficult or impossible to accomplish in small lesions.

(3) It is difficult to interpret the microscopic picture with the accuracy of a permanent paraffin section.

In our hands, aspiration biopsy is reserved for recurrent cystic disease in patients who have had previously, excision of benign cysts or negative surgical biopsies.

Recent unfavorable comparison of excisional vs. incisional biopsy has tended to favor the former procedure. This ancient prejudice, resurrected recently, holds that wide excision of a malignant lump is preferable to cutting into it. We feel with others, that excision usually means cutting across pathways of spread laden with cancer cells in transit and is less desirable than careful, atraumatic incision into the malignant lump in one area. An admonitory example is the uniformly bad results of radical mastectomy following removal of a malignant lump by simple mastectomy.

In our hands, only lesions of 1.5 centimeters or less are biopsied by excision. We feel that the apparent better results of mastectomy following excisional biopsy can be explained by the fact that, clinically benign, small, and therefore more highly curable lesions, were excised in most series, while suggestive or obvious larger lumps were incised.

Authors' Personal Biopsy Routine

Cutting into a cancer or a cancer area for whatever purpose is dangerous and regrettable and is acceptable to most physicians only as a necessary evil for the reasons already stated. It behooves the physician, therefore, to learn and follow a routine and technic of biopsy that is logically and thoughtfully planned to minimize the evils of disturbing the cancer in its bed, but which, at the same time, furnishes information necessary for effective treatment, not obtainable in any other way.

Indications for Biopsy.—A large category of indications might be supplied, but for simplicity's sake, the following general indications should cover the field.

(1) *Any* solitary lump in either or both breasts.

(2) Any lump *unlike other lumps in the breast* as to consistency and character; the so-called *"dominant lump."*

(3) Any area of thickening or hardness in one breast, even though no definite lump is outlined, that persists after the next menstrual period has been completed, or after the menopause.

(4) Every case of bleeding nipple.

(5) Every case of discharging nipple in which Papanicolau smears show abnormal cells.

Removal of Tissue for Microscopic Study.—As the lesion is approached under surgery, its consistency, firmness, the presence or absence of infiltrative changes in the surrounding breast tissue and fat, give valuable suggestions as to the malignancy or benignancy of the lesion. These changes can be sensed, as well as felt, as the knife passes through the tissue. Sharp dissection with the scalpel and not blunt scissors dissection, is employed, for obvious reasons. Depending on the size of the lesion, and the impressions received by the surgeon while doing the dissection, a decision is now made as to whether to excise or incise the lesion. Small lesions 1.5 centimeters or less in diameter are usually excised, whether benign or malignant. Larger lesions, if benign, are widely excised, not enucleated, for fear of local recurrence as in fibroadenoma. If malignant, a careful incision is gently made at one point into the lesion, and a wafer slice of tissue, 1 to 2 millimeters thick, is removed with the scalpel blade.

After removal of all specimens, the wound

is carefully cleansed of all loose tissue and fluid by saline irrigation and the suction tip, and minute hemostasis is accomplished.

After tight layer closure, the incision is sealed with collodion.

Drainage.—In benign cases, although the majority are closed without drainage, we do not hesitate to employ a drain on the slightest indication of seepage. In any biopsy, many ducts, acini, lymphatics, and tiny capillaries are cut across. Seepage can be copious, and difficult or impossible to eliminate. Continuous slight seepage beneath a closed incision can result in tremendous fluid collection and hematoma giving rise to considerable morbidity and embarrassment, all of which can be so nicely obviated by proper drainage that we think it poor judgment to omit it when indicated.

We have found Penrose type tubing to be inadequate as drain material. We prefer soft latex tubing such as a segment of a #12, 14, or 16 T-Tube, suitably trimmed and perforated.

Dressings.—For small, dry, biopsy wounds a simple elastic patch dressing is admirable. Larger more extensive incisions require a "wrap around" dressing of 6″ elastoplast over a small gauze pad. Where small patch dressings are used, brassiere support is begun the day of operation, and is usually continued for 3 to 4 weeks. Unusual postoperative pain is combatted by means of infrared bakes and hot moist saline packs. For home treatment, the patient is instructed to apply to the breast a large Turkish towel wrung out in hot water 2 to 3 times daily if discomfort persists. Salicylates may be necessary at times to relieve aching but usually, in the absence of complications, these patients are remarkably free from pain.

Complications. — Infection is practically never encountered but may be suppressed by hot packs and suitable antibiotics, with incision and drainage rarely necessary.

The most common complications in our experience is hematoma and fluid collection in the breast. If it occurs, the only effective remedy is the opening, partially or completely, of the incision, the evacuation of fluid, and the institution of drainage. Usually this can be accomplished in the office by the removal of one or two skin sutures and the insertion of a sterile suction tip into the wound cavity, evacuating the contents by means of the suction tip with gentle manipulation of the breast. It is remarkable with how little pain this can be accomplished, if skillfully done.

After evacuation, it is imperative that soft, rubber tube drainage be established for a few days to take care of the inevitable recurrent fluid accumulation. Hot packs, external heat, and infrared therapy are valuable adjuvants.

Follow-up.—In the uncomplicated, benign case we like to see the patient in the office at one and three weeks after the removal of sutures, in order to detect any late complications such as buried stitch reactions and the like. A subsequent visit in three months is advisable to check on the quality of the healing, the degree of deep cicatrization and the possibility of recurrence. If fibrocystic "disease" or dysplasia has been found at operation, we advise our patients to have a breast examination by their physician at least every six months. We advise all patients of the value of periodic self-examination of the breasts and furnish them with an explanatory pamphlet of instructions on the technic of self-examination published by The American Cancer Society.

Summary

In order to keep pace with the requirements for early diagnosis of the small breast lesions which are more and more commonly seen today, surgical biopsy is necessary. The alert physician must be willing to subject apparently benign, small breast nodules to surgical biopsy without reluctance in order to pick up the early nondescript breast cancer which has not had time to develop clinical signs or features suggestive of malignancy. The reluctance of physicians to biopsy breast lesions unless circumstances permit immediate radical mastectomy of cancer if found is not truly justifiable. No statistically significant figures are available to show that delay of two weeks or less between biopsy and mastectomy, both properly done, has a detectable effect on five-year survival. Properly performed biopsy, even in an outpatient department office, or clinic, is preferable to a "wait and see" policy, provided appropriate treatment follows the discovery of cancer in two weeks or less.

For these reasons, it is important for surgeon and generalist alike to learn and practice a logical skillful technic of biopsy and to be willing to employ it without hesitation, whenever indicated, in a variety of breast lesions.

Radioactive Iodine And Thyroid Disease*

Kenneth D. McGinnis, M.D.**

Lexington, Ky.

DURING the past several years following a post World War II investigative era, the use of radioisotopes has become widely accepted in the clinical practice of medicine. Radioactive iodine has had an especially important role not only in research work on thyroid physiology but also in the practical aspects of diagnosis and treatment of thyroid disease.

Thyroid Function Tests

The most widely used and probably the best single isotope study of thyroid activity is the 24-hour uptake of I^{131}. This is a safe, simple test that is easily reproducible.[1] For the euthyroid patient, the range of uptake is considered to extend from 12.5 to 45% with only minor variations from laboratory to laboratory. It would be ideal if all results outside of this range could be considered abnormal. This is not the case, and the major portion of investigative activity recently has been with patients in an intermediate range where both clinical and laboratory diagnosis is borderline.

Hyperthyroidism: It can be considered that patients with 24-hour uptake greater than 65% are hyperthyroid. This includes most patients with simple thyrotoxicosis. However, the intermediate range, from 45 to 65%, requires special evaluation. Of the many other radioactive iodine procedures that have been described, two appear to warrant special consideration. The thyroid tolerance test can increase accuracy of diagnosis of thyrotoxicosis in this intermediate group of patients, leaving only a very small number that cannot be correctly categorized. This test is a re-evaluation of thyroid uptake after administration of 70 micrograms of tri-iodothyronine daily for one week. In 95% of euthyroid patients, uptake will decrease by more than 30% at 24 hours. This occurs in only 3% of hyperthyroid patients. The second auxiliary test is determination of the protein-bound iodine conversion ratio. This is a departure from measurement of thyroid accumulation of iodine to a measurement related to the release into the circulation of I^{131} bound to a protein molecule. Values of greater than 45% conversion to protein bound iodine at 24 hours are indicative of hyperthyroidism. This ratio can confirm the false trapping of I^{131} by the thyroid gland that is occasionally responsible for a markedly elevated 24-hour uptake on a patient rendered clinically euthyroid by therapeutic I^{131} administration.

Hypothyroidism: The 24-hour uptake of I^{131} has been a poor test for evaluation of hypothyroidism. The 6-hour uptake should be determined for all patients suspected of hypothyroidism, with values of less than 7.5% being the best indication of decreased thyroid activity.[2] The thyrotrophic stimulating hormone test[3] is useful in the hypothyroid patient. Normal values are from 25 to 40% increase in the 24-hour uptake; in hypothyroidism, the increase is only 1 or 2%. This also offers a method of separating primary hypothyroidism from that due to pituitary hypofunction since in the latter the increase in 24-hour uptake falls within normal range but the uptake itself is of a low initial value.

Nodular Goiter: Thyroid function in the patient with a nodular goiter is a challenge not

*Presented at the third annual fall clinical conference, Lexington Clinic, Lexington, Ky., on October 22-23, 1958.

**From the Section of Radiology and Nuclear Medicine, Lexington Clinic, Lexington, Kentucky.

TABLE I

TEST	NORMAL VALUE	SPECIAL USE
24-hr. Uptake	12.5 — 46	Hyperthyroidism
6-hr. Uptake	7.5 — 25	Hypothyroidism
Conversion Ratio	Less than 46%	Difficult Hyperthyroid Thyroid Carcinoma False Trapping
Thyroid Tolerance	Decrease 30%	Difficult Hyperthyroid
TSH Test	Increase 25%	1° from 2° Hypothyroidism Exogenous-Thy. Depression

only to laboratory but also to clinical evaluation. Results of the I^{131} test may sometimes be either falsely positive or falsely negative. Clinical judgment tempered with results from a battery of thyroid function studies remains the only satisfactory method for evaluation of this difficult problem.[4]

Other Thyroid Activity Studies

One cannot discuss I^{131} studies without consideration of the other laboratory methods of evaluation. There is increasing evidence in the literature that individual tests using basically different approaches may well study only individual functions of the thyroid gland rather than the over-all function as has previously been assumed. These studies, of course, include determination of the basal metabolic rate, serum cholesterol level and the protein-bound iodine value. These offer good supplementary studies, particularly the protein-bound iodine determination, but do not have the range of usefulness or the accuracy in routine determination that is obtained by radioactive iodine studies.[5,6] An exception to this is the determination of the protein-bound iodine level in the patient with a nodular goiter. While still relatively inaccurate, it is better than the standard I^{131} studies.[7]

It is to be noted that all of the iodine studies are effective only because of the borderline iodine starvation level of the average population. One must be aware that iodine-containing vitamin mixtures, iodine-containing radiographic contrast material and other forms of iodine administration represent potential hazards in that they may flood the iodine pool and render all iodine tests inaccurate. If there is question of artificial value without definite knowledge of recent iodine intake, the total serum iodine value can be obtained.[8,9] A level greater than 2 micrograms indicates an abnormal iodine pool.

The special value of each test and its range of normal values is indicated in Table I.

Treatment of Hyperthyroidism

Radioactive iodine is the therapy of choice in most cases of simple hyperthyroidism. Although Clark[10] discusses in detail the contraindications and selection of patients for this form of therapy, almost 90% of all hyperthyroid patients in his series were so treated. Pregnancy and lactation are absolute contraindication to I^{131} treatment as the iodine passes the placental barrier and also gets into the milk. The age of the patient in the reproductive years is itself a relative contraindication both on genetic grounds and for the very remote possibility of radiation-induced thyroid neoplasm. This form of therapy is especially recommended for recurrent hyperthyroidism following surgery, for hyperthyroidism with cardiovascular or other serious concurrent disease and, of course, when surgery is refused. The advantage of I^{131} treatment lies in the near absence of reported mortality, and low morbidity, its safety for the parathyroid glands and recurrent laryngeal nerve, and its ease and economy of administration.

Without going into detail about dose levels, two divergent principles have been proposed. The first is to attempt to render almost all patients euthyroid by a single administration of radioactive iodine. Complications are higher with this method, however, and many patients later require thyroid administration for subsequent hypothyroidism. The preferred method is to stay on the low dosage side while indica-

ting to all concerned that a second treatment may be necessary.

Thyroid Nodules

On the basis of a thorough statistical evaluation, Miller[11] predicted that approximately 3% of all patients visiting physicians would require thyroid surgery if all thyroid nodules were removed as suspected cancer. This is not considered a feasible approach to the problem. Although management of thyroid nodules is an area of considerable controversy, a program that has proved generally satisfactory is surgical removal of the solitary nonfunctioning or cold nodule and medical treatment of the functioning or hot nodule. The hot nodule can be treated with dessicated thyroid for regression if the patient is euthyroid or with I^{131} if he is hyperthyroid.[12] The multinodular goiter is evaluated for surgery on the basis of associated hyperthyroidism, pressure, and cosmetic appearance rather than as a cancer suspect unless an acceleration of growth is noted.[13] Satisfactory regression is rarely achieved by use of I^{131} in the patient with a multinodular goiter, although associated hyperthyroidism can be corrected if this is the major problem.

Mediastinal Masses

A superior mediastinal mass is not a difficult diagnostic problem if it can be demonstrated to be a direct extension substernally from a large thyroid. When the gland is almost entirely substernal without abnormal findings in the neck or when the mass is in an unusual anterior-posterior position, radioactive iodine studies can be invaluable. Such a case is demonstrated in figures 1, 2, and 3 and the following report:

> This 44-year-old patient was asymptomatic but was shown to have a superior mediastinal mass as a result of a routine chest survey film (fig. 1). This mass was posterior to the esophagus, lying within the area of statistical predominance of neurogenic tumors. Close inspection of the chest film and of the laminogram did demonstrate continuity into the neck and an abnormal thyroid mass as well. For confirmation, a scintogram was obtained following administration of a tracer amount of I^{131}. The result of this localization study is shown (fig. 2) superimposed photographically on the laminogram. Figure 3 demon-



Figure 1. Routine chest film of a 44-year-old asymptomatic woman. This mass was posterior to the esophagus.

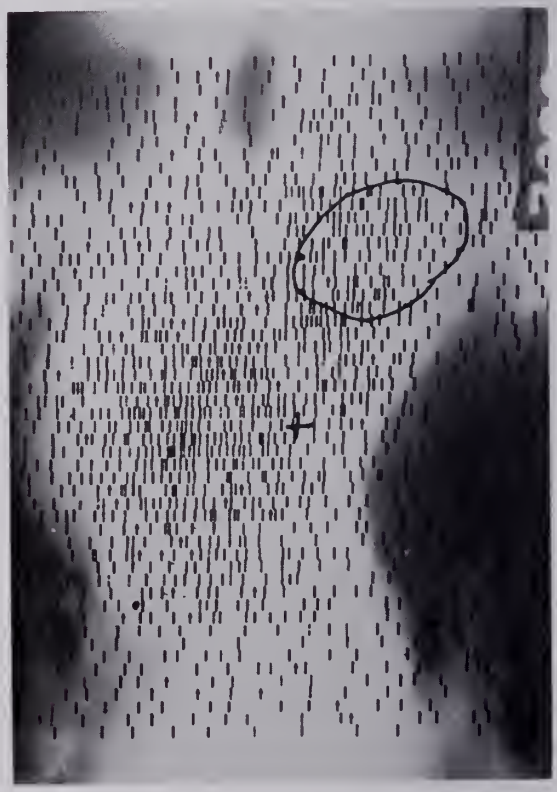


Figure 2. Scintogram of the neck and upper mediastinum superimposed on the laminogram showing I^{131} uptake in the mass.



Figure 3. The benign multinodular goiter demonstrated in its correct anatomical relationships.

strates the mass removed at surgery showing that this benign multinodular goiter conforms to the pattern of iodine uptake of the scintogram.

Thyroid Carcinoma

The treatment of disseminated malignant disease remains an unanswered challenge at this time. There is some promise in the field of chemotherapy, particularly with the lymphomas, and there have been some excellent results with hormonal manipulation in the hormone-dependent tumors of breast and prostate but little else has reached a practical stage. However, certain cases of thyroid malignancy have responded dramatically to radioactive iodine.[14,15] As pointed out by Cunningham,[16] effectiveness of treatment depends both on the sensitivity of the tumor to the radiation and on the degree of its uptake of I^{131}. Because it is probably much more important, the amount of uptake has received much wider attention. The histological appearance is also very important in the evaluation for possible I^{131} therapy. Most good results have been in those with tumors that are fairly well differentiated with colloid formation. The conversion ratio mentioned previously as a thyroid function study can have great value in determining the degree of function of metastatic thyroid carcinoma if the normal thyroid has been totally removed or destroyed with I^{131}. It is interesting to note that the circulating protein-bound iodine fraction in thyroid carcinoma contains an abnormal compound, the so-called Compound X, that is bound on chromatographic studies to the albumen fraction rather than to a specific alpha globulin, as is thyroxin. Determination of the relative amount of this abnormal product gives another method of following tumor behavior. It is sometimes possible to localize by tracer study metastatic areas of functioning thyroid carcinoma in bone or lung before there is positive radiographic evidence. An illustrative case:

> In the case of this 66-year-old male a diagnosis of thyroid carcinoma was made in 1953. At the time of the initial surgical procedure, the left lobe of the thyroid and the isthmus were removed and an ipsilateral radical neck disection done. One node was involved with carcinoma. The patient did well for three years, after which recurrence was found in the ilium (fig. 4), the chest wall, and the left hilar lymph nodes. Iodine uptake studies indicated localization of the radioactive material in these lesions. A biopsy specimen from the chest wall demonstrated a fairly well differentiated papillary carcinoma with glandular arrangement of cells and colloid formation very similar to the original lesion. He was given a total of 275 millicuries of I^{131} over a 5-month interval. The hilar nodes decreased in size and there was considerable recalcification of the bone lesions (fig. 5) at an interval of 18 months. This patient was asymptomatic in May 1958, nineteen months after symptomatic metastasis appeared.

Although individual experiences are not sufficient for statistical analysis, there have been many individual reports of long-term good results that justify use of I^{131} whenever possible in metastatic thyroid carcinoma.



Figure 4. Osteolytic metastasis from thyroid carcinoma in the ilium.



Figure 5. Partial recalcification of this metastatic area 18 months after therapeutic I^{131}. Note recalcification in metastatic areas not visualized before healing.

Summary

1. The 24-hour uptake of I^{131} by the thyroid gland is the most practical single test for suspected hyperthyroidism.

2. The conversion ratio, the 6-hour uptake, the thyroid tolerance test and the TSH test are valuable ancillary tests of thyroid function.

3. Radioactive iodine is useful in evaluation of the solitary thyroid nodule and in the differential diagnosis of superior mediastinal masses.

4. The treatment of choice in simple hyperthyroidism is usually I^{131}.

5. Dramatic results can be achieved with I^{131} in certain cases of disseminated thyroid carcinoma. The progress of treatment of thyroid carcinoma can be followed by use of the conversion ratio when no normal thyroid tissue remains.

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The Diagnosis and Treatment of Thyroiditis*

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TODAY'S practicing doctor is likely to be confronted with three entities which have been given the name "thyroiditis." One of these, which is becoming more common and is iatrogenic, is induced by therapy with radioactive iodine. Another, for which the designation "thyroiditis" is inept, is Hashimoto's disease or struma lymphomatosa. And the third is the subacute thyroiditis of De Quervain. Although the literature concerning the thyroid includes much that is new and useful in the understanding and treatment of these diseases, this knowledge has not been widely disseminated in textbooks and the nonspecialty journals.

Classification

A classification of types of thyroiditis helps to define the discussion, and makes known the variety of diseases usually included under this heading. A standard grouping is as follows:

I. Specific thyroiditis.
   - A. Bacterial.
   - B. Parasitic.
   - C. From radiation therapy.

II. Nonspecific thyroiditis.
   - A. Subacute thyroiditis (De Quervain).
   - B. Struma lymphomatosa (Hashimoto).
   - C. Struma fibrosa (Riedel).

Since it is doubtful that most present day physicians will ever see a case of specific thyroiditis of bacterial or parasitic origin, no further discussion will be made of these types. With the advent of chemotherapeutic and antibiotic agents, suppurative thyroiditis has almost become extinct. The types of thyroiditis to be discussed in this paper are never suppurative.

Subacute Thyroiditis

Subacute thyroiditis is an inflammatory disease of unknown etiology, which may be acute, subacute, or chronic, but it is always self-limited. An outbreak in which there was good evidence for the relationship of this type of thyroiditis to the mumps was recently reported in Israel.[1] It is not ordinarily an epidemic disease, however, and it is questionable that the usual sporadic cases are casually related to the mumps virus. Because of its pathological nature, this entity has been called such names as giant-cell thyroiditis, granulomatous thyroiditis, and acute nonsuppurative thyroiditis. The thyroiditis appears to develop in an otherwise normal gland. In the Mayo Clinic series, enlargement of the gland was unilateral in 50 per cent of the cases.[2] Examination of pathological material shows active inflammation, destruction of follicles, and a tuberculoid reaction, and it is a bit surprising that clinically all signs and symptoms should subside completely in a matter of weeks or months.

Although the clinical diagnosis is not usually difficult, it is missed with surprising frequency. At least as common a disease as struma lymphomatosa, subacute thyroiditis is not rare, and the diagnosis is usually simple if it has been considered. Because of the degree of local pain and tenderness, needle biopsy of the gland is not done during the acute stage of the disease, and reliance must be placed on the history, which is usually typical. The patient will note a fairly acute onset with pain and tenderness in the region of the thyroid, pain referred to the ears or jaws, malaise, dysphagia, and the symptoms of recent pharyngitis or an upper respiratory infection. The majority of cases occur in women; at the Lexington Clinic during

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a nine-year period (through 1957), 14 of the 16 patients with subacute thyroiditis were women. These patients are rarely seen by us during the first few weeks of symptoms; more often their first visit is after one to two months. The sedimentation rate is usually elevated; in eight of these patients it varied from 14 to 116 mm. with a mean of 55 mm. (Westergren method).

The most valuable thyroid function test in subacute thyroiditis is the uptake of radioactive iodine. The uptake is depressed virtually to zero in the acute phase. This depression may persist for only a week or two in the milder cases or for more than two months in the very severe cases. A euthyroid interphase and then a transient increase in uptake ("rebound phenomenon")[3] may follow. The protein-bound iodine (PBI) value, like the basal metabolic rate (BMR), may be elevated during the acute phase, but in my experience these two tests are usually of little aid in the diagnosis. It might be expected that results of these tests should be high during the acute phase, since this phase is associated with a clinical state simulating hyperthyroidism. Perhaps we do not find these tests more helpful because we rarely see the patients during the first few weeks of their illness.

Although one study[2] reported that myxedema occurred in 12 of 108 patients in a late stage of subacute thyroiditis, nine of these patients had had bilateral subtotal resection of the gland. In our experience permanent myxedema has never resulted from this disease in the absence of surgical intervention. That a transient period of hypothyroidism is not unusual has been stressed by others,[3] and the clinical course of the full-blown disease has even been divided into four phases: thyrotoxic, euthyroid, hypothyroid, and recovery. The hypothyroid phase is likely to occur only in the most severe cases and to last for only two to six months if there has been no surgical intervention.

It is interesting to compare the courses of subacute thyroiditis and the thyroiditis induced by radiation. In both there is local pain and tenderness. Destruction of the follicle floods the tissue with excessive amounts of stored thyroid hormone. In both, then, the serum protein-bound iodine level may rise temporarily and symptoms of hyperthyroidism appear (or become worse). This new type of thryoiditis induced by therapeutic doses of I^{131} occurs in about 5 per cent of patients so treated for thyrotoxicosis.[4] In contrast to subacute thyroiditis, in the radiation-induced condition the local symptoms do not persist for longer than a week. A transitory or permanent state of hypothyroidism is not unusual three months following the therapy.

Hemorrhage into an adenoma or (carcinoma) of the thyroid may simulate thyroiditis. If the patient with subacute thyroiditis is seen during the first few weeks of symptoms, results of an I^{131} uptake study will be low while the PBI value is high, but both will be normal if the clinical picture is produced by hemorrhage into an adenoma. In the usual diffuse cancer with impaired uptake of I^{131}, the serum PBI value should be low rather than high. If still uncertain about the diagnosis, some physicians[4] give 300 mg. of cortisone the first day and 200 mg. a day for two more days. There should be a dramatic response if the condition is subacute thyroiditis.

There are three forms of treatment in common use today for this type of thyroiditis: steroids, x-ray, and the antithyroid drugs. The use of cortisone and corticotrophin (ACTH) or their analogues has become increasingly popular. This is so despite the tendency for the disease to relapse if only short courses of treatment are given. Prednisone is as effective as cortisone and usually gives immediate relief. Because of the relapse rate it is probably wise to continue steroid treatment, once begun, for at least four to six weeks. A small amount of x-ray, usually a total dose of 600 to 800 r (in fractional dosage), is an effective treatment by itself, and there has been a tendency in recent years to employ both agents in treatment. This is my own preference when there is no contraindication to steroids. Sometimes recurrence of symptoms or spread to the other lobe requires a second course of therapy. Antithyroid drugs and the use of desiccated thyroid have not proved of equal value to steroids and x-ray, and antibiotics have proved to be of no value.

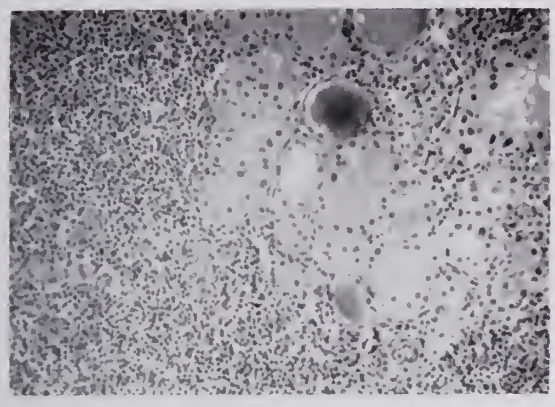


Figure 1.

Section from thyroid with Hashimoto's disease.

Hashimoto's Disease

The goiter of Hashimoto's disease is not, strictly speaking, a "thyroiditis," but it is characterized by a replacement of normal thyroid tissue with a mixture of lymphadenoid tissue (usually arranged in nodes containing "germ centers") and Hürthle cells, accompanied by some fibrosis and little or no storage of colloid. Although the typical pathological appearance is diagnostic (Figure 1), there are disturbing variants, and the diagnosis must often be made using both clinical and histological criteria. There are many examples of hyperplastic and nodular goiters associated with lymphocytic infiltration and trabecular fibrosis that do not fulfill strict pathological or clinical criteria for Hashimoto's disease. No discussion will be made of this heterogeneous group.

Hashimoto's disease is a common cause of goiter, and many people feel that its incidence is increasing. Peculiarly, 90-99 per cent of the cases occur in women, usually those between 20 and 60 years of age. Of 14 patients in whom we have been able to make the diagnosis over a five-year period, all but one were women, and pathological material is available in eleven. There is considerable controversy about the possibility that this disease represents an auto-immune reaction. Immunological studies have shown that the serum of patients with Hashimoto's disease contains a precipitating antibody which reacts specifically with human thyroglobulin.[6] It is interesting to speculate about the relationship of these findings to the pathogenesis of the disease, and these studies have also focused attention on new diagnostic tools in this disease. There is an increase in gamma globulins in the serum, which, in the absence of liver disease, gives rise to abnormal results of flocculation tests.[6, 7] The typical electrophoretic pattern in *hypothyroidism* apart from Hashimoto's disease is an elevated beta globulin fraction and a normal gamma globulin fraction, whereas in Hashimoto's disease the results are reversed (Figure 2).

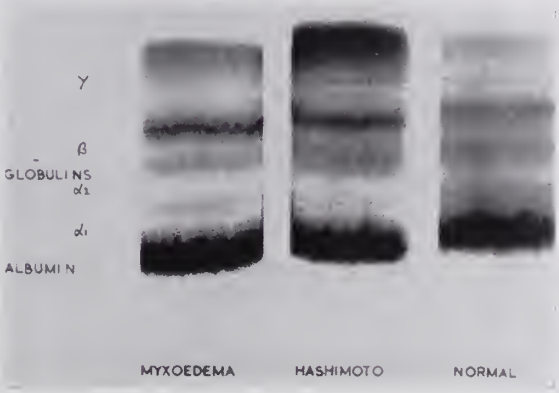


Figure 2.

Electrophoretic patterns of the serum proteins in Hashimoto's disease. (J. Clin. Endocrinol., 18:99-108, 1958.)

The importance of the diagnosis of Hashimoto's disease rests chiefly on two principles: (1) the avoidance of unnecessary surgery in a nodular goiter and (2) the understanding that these patients almost invariably develop myxedema if left untreated. The finding of a goiter in a myxedematous adult is almost pathognomonic. But prior to the development of full-blown myxedema, which may take years, there are many helpful clinical criteria. The goiter is usually firm and "rubbery," and it may be smooth or lobulated. Although diffusely enlarged, it may be asymmetrical. The BMR is usually below 0 per cent regardless of the presence or absence of symptoms and signs of thyroid failure. The PBI value is often normal, but that of BEI (butanol-extractable iodine), which more accurately measures circulating thyroxine, is frequently low.[8] There is an unusual iodinated protein (noncalorigenic) in the serum of these patients which probably accounts for this difference.[9]

The I^{131} uptake, in contrast, is usually normal or elevated even in the presence of myxedema. To this battery of helpful tests can now be added the serum colloidal-gold test, which correlates with the rise in gamma globulin in this disease. In summary, then, the preoperative diagnosis of this disease can be made, even in the absence of myxedema, by finding a firm, diffusely enlarged goiter in a patient with a normal PBI, a normal or low BMR, and a normal or high I^{131} uptake. If further diagnostic techniques are still needed, additional help may be gained by use of the needle biopsy, the serum colloidal-gold test, and the thyroid-stimulating hormone (TSH) test as proposed by Skillern et al.[8] In Skillern's group of patients with struma lymphomatosa 4 U.S.P. units of TSH did not induce a significant increase in the uptake of a second tracer dose of I^{131}, regardless of the initial uptake.

Once the diagnosis is established, the treatment of Hashimoto's disease involves the permanent use of a sufficient amount of uncoated desiccated thyroid. This is usually two to three grains of U.S.P. thyroid daily. A reduction in goiter size can be expected in two to three months, with an eventual further reduction and occasional disappearance of the goiter. Surgery is rarely necessary, but if there is not a prompt response to thyroid, the possibility of an associated (and unrelated) malignancy must be considered. Whenever surgery establishes the diagnosis of Hashimoto's disease, the patient should be started on thyroid treatment immediately, since it is almost inevitable that myxedema will develop in time.

Riedel's Struma

Very little need be said regarding Riedel's type of invasive fibrous thyroiditis, since most physicians will never see a case and, if they do, the proper preoperative diagnosis should be carcinoma. The Mayo Clinic sees about one case every two years, and the Lexington Clinic has seen only one case during the 1950-1957 period.

The thyroid gland is very hard, symmetrically enlarged, and fixed to surrounding structures. Pressure symptoms are marked, and prior to biopsy the patients are invariably thought to have an inoperable cancer of the thyroid. This condition is strictly a surgical problem, and decompression of the trachea becomes necessary.

Summary

The two types of thyroiditis most frequently encountered are subacute thyroiditis and Hashimoto's disease. Subacute thyroiditis is a self-limited disease of unknown etiology, characterized by a tender gland with a diminished I^{131} uptake in the acute phase. Although there is no cure, adrenal steroids and x-ray treatment offer good symptomatic relief. Hashimoto's disease is a distinct and increasingly common clinical entity which must be differentiated from other types of nodular goiter. This can usually be done by finding a rubbery, diffusely enlarged gland, a BMR below 0 per cent, and a normal to high I^{131} uptake. Patients with Hashimoto's disease will have myxedema or will eventually develop it, and the proper treatment is desiccated thyroid.

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Plasma Protein Fractionation By Paper Electrophoresis*

Its Application to Clinical Medicine

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THE determination of human plasma protein fractions by salt precipitation techniques may impart a false impression of the individual components. This is known to occur as a result of incomplete separation of globulin from albumin. For example, with the chemical technique, alpha-globulin may be partially precipitated with albumin. Likewise, beta globulin may be partially carried in either the albumin or gamma-globulin fractions.[1]

It is apparent, therefore, that in conditions in which the albumin may be low and the alpha-globulin increased, the reduction in albumin may be minimized by the precipitation method. This can be observed in acute infectious diseases where the lowered albumin is masked by a rise in alpha globulin.[2] On the same basis the A/G ratio may remain normal in nephrosis and acute hepatitis despite a definite decreased albumin and increased beta globulin.[2]

Agammaglobulinemia

The limited value of the standard A/G ratio under certain circumstances and the additional information which electrophoretic fractionation can provide, may be demonstrated in a variety of disease states. One of the few definite disease entities that require electrophoretic fractionation for definite diagnosis is agammaglobulinemia and hypogammaglobulinemia. The cardinal manifestation of this disease is an extremely low to absent gamma-globulin in the presence of normal remaining serum protein fractions.[3, 4] The clinical manifestation of this disease consists of recurrent infections, absence of acquired antibodies, lack of isohemagglutinins, failure of long term antibiotic therapy to provide protection and a favorable clinical response to protective injections of gamma-globulin.

This deficiency may confuse the interpretation of tests dependent upon abnormalities in the gamma-globulin component, such as liver function tests[5] and misdiagnosis may result. Agammaglobulinemia occurs as a congenital defect and is usually diagnosed in children, but can be proven to exist in forebears. Hypogammaglobulinemia, in acquired form, usually occurs in the adult and can result from a number of long term illnesses. This deficiency is explained by the decreased amount of precursor presented to lymphoid tissue for synthesis, or as an increased utilization over synthesis.[6] A disease entity in which this occurs is multiple myeloma, in which beta-globulin or "M" component is increased at the expense of normal precursor of gamma-globulin. Hypogammaglobulinemia usually occurs as a result of destruction of lymphoid tissue as in cancerous replacement of this tissue, radiation damage, or damage to lymphoid tissue by benzol or nitrogen mustard. Rapid loss is also a common cause as in the nephrotic syndrome,

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familial idiopathic dysproteinemia and occasionally in Cushing's Syndrome.

Cryoglobulinemia

Serum protein fractionation by electrophoresis has also been of extreme value in the study of disease states consisting basically in the production of plasma globulin of unusual properties.[7, 8, 9, 10] In various diseases of the reticuloendothelial system, cryoglobulin and macroglobulin may exist together or singly. Cryoglobulin is a special protein precipitating at 4° to 6° C. The reaction is reversible. Cryoglobulins are associated with multiple myeloma most commonly, but can be found in a variety of chronic disorders associated with hyperglobulinemia, including chronic lymphatic leukemia, lymphosarcoma, subacute bacterial endocarditis, kala-azar, malaria, polyarteritis nodosa, rheumatoid arthritis, lupus erythematosus and other inflammatory conditions, all of which show involvement of the reticuloendothelial system.

Cryoglobulinemia can be essential and is often, but not invariably characterized by a definite clinical syndrome, the features of which are intolerance to cold, as manifested by Raynaud's phenomenon, purpura, urticaria, ulceration of the skin, peripheral gangrene and retinal vascular stasis. The purpuric component of the disease is explained by the electrophoretic demonstration[8, 9] of precipitated cryoglobulin carrying with it fibrinogen and other coagulation factors. Likewise, surface damage of red blood cells, white blood cells, and platelets, and bone marrow injury occurs, resulting in cytopenia and pancytopenia. Similar circumstances exist in macroglobulinemia. The term macroglobulinemia has been reserved for serum containing more than 5 per cent of components sedimenting with Svedberg constants greater than 15. Thus, it is apparent that absolute isolation of macroglobulins (globulins of very large molecular weight, usually a million or over) is necessary to make the diagnosis. But, macroglobulins have the electrophoretic mobility of beta or gamma-globulins. Patients with Waldenstrom's Syndrome of macroglobulinemia suffer from lassitude, dyspnea, mucosal bleeding, pallor, edema, slight hepatosplenomegaly, painless mild enlargement of lymph nodes, elevated sedimentation rate, anemia and lymphocytosis. The bone marrow often reveals large numbers of small atypical "lymphocytic cells" with protoplasmic shedding. Leukopenia, pancytopenia and acquired hemolytic anemia have all been observed. It appears probable that many atypical cases of myelomatosis and chronic lymphatic leukemia actually represent instances of macroglobulinemia. But the disease entity must be differentiated from purpura hyperglobulinemia, and an electrophoretic pattern here is of definite assistance since the globulin peak is sharp in macroglobulinemia, whereas a broad hump is characteristic of the latter. The presence of cytopenia and pancytopenia are predominant features of the above discussed abnormal protein disease. Ultracentrifugal examination of serum seems of paramount importance in ill defined hematologic disorders.

Other Diseases

In other disease states in which abnormal proteins are not characteristic, the electrophoretic pattern may be particularly helpful. Alpha-globulin is increased in febrile illness of any etiology, but may also be increased in collagen disease and malignant disease.[11, 12] The greatest increase in beta globulin occurs in nephrosis and acute hepatitis.[2] This may be of definite help in differentiating acute hepatobiliary disease with jaundice from chronic hepatic disease. In multiple myeloma, the abnormal protein pattern often occurs in a gamma component, but the so called "M" component may replace or encompass the normal globulin component and reveal a sharp peak.

Method

The following is the method used by us to obtain the small series of studies illustrating our experience:

Electrophoretic fractionation was performed using a Spinco model R system.[13] In this procedure serum blood samples are applied to paper strips saturated in an electrolyte buffer. The proteins in the sample are separated in an electrical field which causes the various components to migrate as separate bands along the strip. The strips are then dyed with bromphenolblue. The concentrations of the protein fractions are determined on the basis of light absorption of the stain in an automatic densitometer which draws a curve of color density versus distance scanned along the paper strip. At the same time the area under the curve is

measured and quantitatively related to the particular component.

Results

The following case reports were selected on the basis of their characteristic electrophoretic patterns: (Normal pattern, Fig. 1)

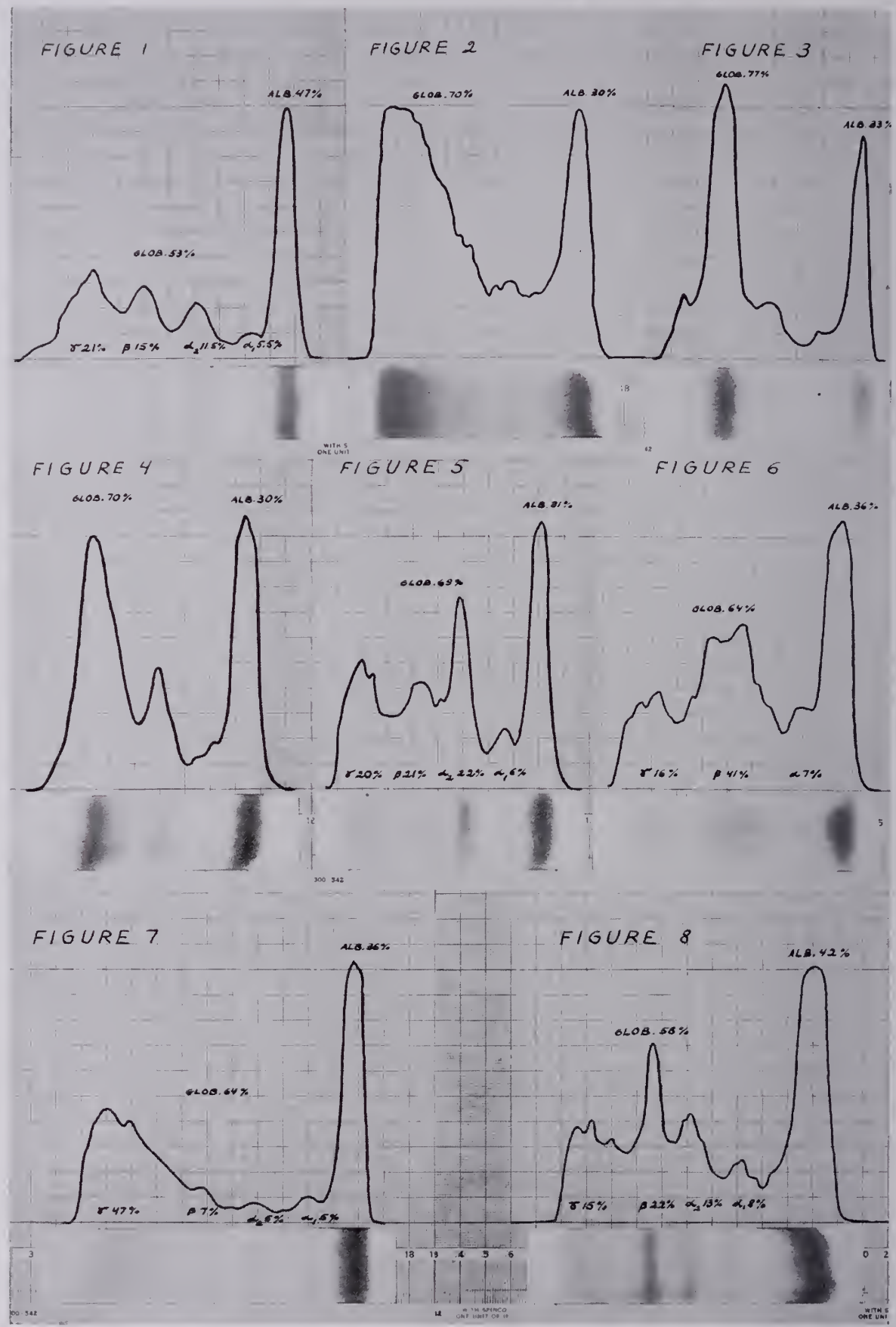
Case #1. F. H. Female age 63. The patient was previously diagnosed as having hypoplastic anemia. She was readmitted to the hospital for blood transfusions and further studies. On admission the Hgb. was 9.8 gms. RBC 3.8 million, WBC 4,800, with an essentially normal differential count. The urine was normal. An aspiration of the iliac crest revealed a marrow of about normal cellularity, some increase in lymphs, and otherwise normal maturation. The patient received 2 pints of blood which increased the Hgb. to 12.9 gms. A subsequent electrophoretic study of serum proteins disclosed the following distribution: Albumin 30%, globulin 70%. The abnormal globulin had its peak in the gamma band and was also dragged through the beta portion. The diagnosis of macroglobulinemia was made. (Fig. 2)

Case #2. H. K. A 76-year-old male was readmitted to the hospital because of weakness and hemorrhages on face and gums after trauma. He had a history of bleeding for 6 years. Two years previously he was diagnosed as having chronic lymphatic leukemia. The laboratory studies now showed a Hgb. of 6.4 gms. RBC 2.6 million, WBC 4,000 with 43 polys, 52 lymphs, 1 band cell and 4 monocytes. Normal coagulation time was obtained. The urinalysis showed a 2 plus albumin. The platelet count was 34,000. The patient received several blood transfusions and while crossmatching his blood it was noticed in the laboratory that his serum was of very thick consistency and resulted in gel formation. An electrophoretic study revealed an abnormal pattern with an increase of globulin (77%) which was mainly spread through the gamma and beta fractions. Macroglobulinemia was inferred. (Fig. 3)

Case #3. C. C. Female 67 years old. The patient had been diagnosed as having osteoporosis and neuritis. She was treated by bed rest and drugs at home. As her condition became worse, she was admitted to the hospital with tenderness in the lower dorsal spine, with radiating pain to the posterior chest, and pain in the mid-sternum and abdomen on pressure. The admission CBC was normal (Hgb. 13.7 gms. RBC 4.2 million, WBC 6,000 with 78% polys). Urine showed a 1 plus albumin. Her EKG was normal. X-ray studies revealed a mass lying against the chest wall in the right upper axillary line from the 1st to the 3rd rib. There was also a mass in the mediastinum to the right of the aorta. Multiple myeloma was suggested. A subsequent sternal puncture revealed a plasma cell myeloma. An A/G ratio done at this time revealed an albumin of 3.3 grams, a globulin of 4.5 grams. A Bence-Jones protein was negative at this time, even though a positive result was obtained 8 days later. An electrophoretic study of serum proteins showed a typical pattern of multiple myeloma with an increase in gamma-globulin. (Fig. 4)

Case #4. R. J. 59-year-old female. The patient was admitted to the hospital because of a swollen, tender thyroid gland. This was associated with fever and chills for the past 2 weeks. Physical examination revealed nothing significant except enlargement and induration of the thyroid. Admission laboratory work showed a normal CBC and urine and a negative X-ray of the chest. A BMR was minus 23 and minus 17. An A/G ratio was 4.3 over 3.2. Total cholesterol was 175 mgm.%. Initially the patient's temperature was elevated to 99.8 degrees F. and returned to normal in a day with subsequent slight fluctuations. Repeated blood cultures were negative. An electrophoretic study of serum proteins revealed an increase in alpha-2-globulin. The patient was discharged three days later and the final diagnosis recorded was subacute thyroiditis. (Fig. 5)

Case #5. M. P. A 27-year-old male was admitted with recurrent attacks of pericarditis. His temperature was 102° F on admission. Admission workup showed a Hgb. of 15.1 grams, RBC 5.3 million, WBC 16,500 with 80% polys. The C-reactive protein was 4 plus, antistreptolysin titer 50 Todd units. During the evaluation the possibility of an allergic reaction, poly-arteritis, or other systemic disease was considered. A muscle biopsy did not disclose any evidence of polyarteritis nodosa.


FIGURE 1
ALB. 47%
GLOB. 53%
γ 21% β 15% α2 11.5% α1 5.5%
FIGURE 2
GLOB. 70%
ALB. 30%
FIGURE 3
GLOB. 77%
ALB. 23%
FIGURE 4
GLOB. 70%
ALB. 30%
FIGURE 5
ALB. 31%
GLOB. 69%
γ 20% β 21% α2 22% α1 6%
FIGURE 6
ALB. 36%
GLOB. 64%
γ 16% β 41% α 7%
FIGURE 7
ALB. 36%
GLOB. 64%
γ 47% β 7% α2 6% α1 5%
FIGURE 8
ALB. 42%
GLOB. 58%
γ 15% β 22% α2 13% α1 8%

Figures 1-8

Three L. E. tests were negative. The cephalin flocculation test was negative. An X-ray film of the chest did not disclose any active cardiopulmonary pathology. A subsequent EKG supported the diagnosis of recurrent pericarditis. An electrophoretic study showed an increase in globulin (64%), most of it occurring in the beta section (41%). The patient became very uncooperative and was discharged with a diagnosis of acute non-specific pericarditis. (Fig. 6)

Case #6. R. C. A 59-year-old male was considered on admission to have Addisonian anemia or a gastrointestinal malignancy. Previous history of acute cholecystitis and low grade pancreatitis 4 years ago was obtained. Admission work-up revealed 6.3 grms. of Hgb., RBC 2.8 million, WBC 8,000 and an essentially normal differential. The urine was negative. The Schilling test with Co^{60} was negative for pernicious anemia. A red cell fragility test was essentially normal. An A/G ratio showed 4.95 grams of albumin, 2.35 grams of globulin. The stool was negative for occult blood. A gastric analysis showed normal acidity. A Coombs test was negative. Serum bilirubin was normal. Cephalin flocculation test was normal. Platelet count was high normal. MCV, MCH, MCHC were all below normal. Urobilinogen was not increased in the urine. Reticulocytes were 0.9%. A bone marrow aspiration revealed a normal marrow. X-ray of the upper gastrointestinal tract showed no evidence of ulcer, malignancy or varicosities of the esophagus. An electrophoretic study of Hgb. showed no abnormalities. An electrophoretic study of serum proteins revealed an increase in beta globulin. The final diagnosis was acute hemolytic anemia, probably toxic. (Fig. 8)

Case #7. J. C. Female 21 years old. The patient had had one admission one year ago, during which a diagnosis of thrombocytopenic purpura was made. Six months ago she was admitted for the second time because of acute rheumatic fever. An electrophoretic fractionation of serum protein was then done with the following resuts: Albumin 35%, Globulin 65%, of which 38% was gamma, 12% beta, 8% alpha 2 and 7% alpha 1. Presently she was admitted because of noted difficulty in typing her blood. Her admission urine was negative. The CBC showed 9.7 grams of Hgb., RBC 3.5 million, WBC 7,400 with 77% polys, 19 lymphs and 4 monos. The following abnormal findings were recorded on additional laboratory work: Albumin 2.7 grams, globulin 5.1 grams. Platelet count was 512,000, reticulocyte count 8%. A positive direct Coombs test and a positive LE preparation were obtained. An electrophoretic study revealed an abnormal pattern with 36% albumin and 64% globulin, of which 47% was gamma, 7% beta, 5% alpha 2 and 5% alpha 1. The patient was discharged with a diagnosis of disseminated lupus erythematosus. (Fig. 7)

Discussion

Six cases showing abnormal electrophoretic fractionation of proteins are presented. Cases 1 and 2 show the presence of abnormal macroglobulins, confirmation of which of course, would depend upon ultracentrifugation. As observed by others, in one case the macroglobulin traveled in the gamma and in the other case it traveled in the beta globulin band. In macroglobulinemia, illustrated by case #2, bleeding tendencies are common and are explained by absorption of coagulation factors upon macroglobulins. In view of the fact that case #2 had a previous diagnosis of lymphocytic leukemia, and that case #1 showed some increase in lymphocytes, it may be interesting to note that large numbers of lymphocytes in peripheral blood and bone marrow were reported to be usually found in macroglobulinemia.[2]

An increase in alpha 2 globulin as demonstrated in case #4, has been observed in thyroid disorders as well as other acute febrile conditions.[2]

Case #5 had a marked increase in beta globulin which is usually elevated in chronic infections even though this also would have been compatible with a diagnosis of periarteritis nodosa.[14]

Case #3 reveals a typical pattern seen in multiple myeloma but is non-specific. The appearance of so-called "M" protein may occur in the alpha, beta or gamma bands.

Case #6 is presented here to demonstrate the realm of the unknown in relation of protein

fractions to obscure blood dyscrasias. A final diagnosis in this case has not been made.

Summary

In summary, the advantages offered by electrophoretic fractionation of serum proteins over the standard chemical method seem to be: first, a more accurate separation of components, particularly alpha globulin from albumin, thus avoiding confusion in interpretation of results. Secondly, the diagnosis of such disease states as agammaglobulinemia and hypogammaglobulinemia rests upon the demonstration of the absence or deficiency of gammaglobulin by this technique. Thirdly, abnormal protein disease such as cryoglobulinemia and macroglobulinemia may be demonstrated in association with ultracentrifugation studies, by electrophoretic technique, which seems to provide a partial explanation for the abnormal bleeding tendencies that occur in these diseases.

Supportive, but not specifically diagnostic demonstration of abnormal globulin fractions is obtained from electrophoretic studies in such disease states as multiple myeloma, collagen disease, infectious and toxic diseases. Alphaglobulin may be said to be increased in acute febrile illnesses. The greatest increase in beta globulin occurs in nephrosis and acute hepatitis and may be of definite help in differentiating acute hepatobiliary disease with jaundice from chronic hepatic disease. Increases in gammaglobulin occur in all chronic inflammatory diseases.

The protein electrophoretic study has been stated by some clinical investigators to be of greatest value in following the course of long term inflammatory or neoplastic disease rather than assisting in making specific diagnosis.

Acknowledgement is made to Drs. Marion Beard, Robert Dyer, Samuel Smith, Clyde Moore and Foster Coleman for their permission to use the case histories of their patients in this presentation.

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The Artificial Kidney In Renal Dysfunction*

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and

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IT is not the purpose of this paper to discuss the technical aspects of the artificial kidney or present the advantages of one hemodialyser over another. It is our purpose to outline the indications and limitations of hemodialysis so that the physician confronted with the problem of acute renal dysfunction may be advised not only as to the immediate procedure, but when to consult a center in which an artificial kidney is available. It is fundamental to realize that the artificial kidney is not a solution to the problem of acute renal dysfunction, but is merely a single facet in its clinical management.

Limitations

The artificial kidney serves primarily to correct the electrolyte imbalance that is associated with renal dysfunction. It has the ability to correct the electrolyte imbalance which has extended beyond the possibility of correction by parenteral fluids or medication and offers a means of removing fluid which has for one reason or another accumulated in the body. Certain types of artificial kidneys may, by ultra filtration, correct the overhydration caused by unwise attempts to force kidney function. The artificial kidney can not replace the patient's kidneys except for a few hours and the ultimate answer must be always for the patient's renal status to improve sufficiently to afford diuresis and relatively normal function.

Diagnostic Steps

What then is the procedure to be followed when a patient develops acute renal dysfunction with anuria? First, the physician must examine the patient's tongue, skin and previous fluid intake and eliminate the possible cause of simple dehydration. Second, the patient must be catheterized to be sure that there is not an accumulation of urine in the bladder. The catheter should be left in place so that during treatment the urine out-put can be accurately measured. Third, the patient's renal pelves should be catheterized by cystoscopy to eliminate the possibility of a ureteral obstruction.

If dehydration and an obstructive uropathy are not responsible for the anuria, a complete electrolyte panel of the blood should be obtained. This should include sodium, chloride, potassium, carbon dioxide combining power, calcium, phosphorus, non-protein nitrogen or urea nitrogen and creatinine. A complete blood count and a hematocrit is essential. The hematocrit affords information as to blood concentration and permits an accurate estimate as to the possible latitude of fluid administration. All of these studies must be repeated at daily intervals to follow intelligently the patient's course. The potassium value of the blood is of extreme importance and as it approaches 7 mEq. per liter it signifies impending doom and demands immediate action and the prompt application of hemodialysis if it is to be used at all. It is imperative that the electrolyte picture must be maintained within relatively normal limits both by oral or parenteral medication and fluids. The carbon dioxide combining power demonstrates the degree of acidosis during uremia and must be maintained within normal limits by the administration of either saline, sodium bicarbonate or 1/6 M. sodium lactate-r.

Essentials of Treatment

The following affords a thumb nail sketch of the essentials in the immediate treatment of

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intrinsic renal dysfunction with anuria:

1. Limit the daily fluid intake to not more than 500 cc. plus whatever is lost in the sweat, vomitus, stools and urine.
2. High carbohydrate diet since proteins upon utilization add to the nitrogen of the blood.
3. Avoid drugs to control vomiting because of a possible toxic cumulative effect. Instead, administer intravenously, 10 to 50 per cent glucose which is covered by 1 unit of regular insulin for each 5 gm. of glucose.
4. Potassium absorbing resins may be used either orally or rectally.
5. Testosterone (10 to 25 mg. daily) provides a protein sparing effect.
6. Corticoids or corticotropin (ACTH) may influence diuresis on or after the third day of anuria.
7. Drugs as indicated for specific associated situations; i.e., infections, injury, shock. However, here again the possibility of drastic cumulative effects in a patient without adequate powers of excretion must be considered.

The above mentioned procedures are to be used from the outset of renal failure, but the patient's clinical and chemical course must be carefully observed. If there is no evidence of improvement by the third day of anuria, dialysis should be instituted. It is imperative that those in charge of hemodialysis have the advantage of seeing the patient well before the urgency of the preterminal uremic state is manifest.

Critical Signs

The indications of an approaching terminal uremic state are varied, but a few will be mentioned to acquaint the physician with these critical signs.

1. Potassium level of the blood of 7.0 mEq. per liter or a CO_2 combining power of 12 mEq. or less.
2. Drowsiness, confusion, irritability, restlessness, ankle clonus, reflex hyperactivity, papilledema or retinal edema.
3. Tachycardia or pulmonary congestion.
4. Vomiting, retching, ileus, persistent wrinkling of the scrotum and areola of the breasts.

Indications

There are several indications for hemodialysis but it is important to realize that each situation must be individualized. In considering dialysis it must be remembered that ultrafiltration is as important as dialysis and that either may take precedence over the other. For example, early in uremia the appearance of neurological manifestations due to cerebral edema may demand ultrafiltration, for if the cerebral edema is permitted to exist until dialysis is indicated it may result in a living patient with permanent brain damage.

Dialysis is valueless in the presence of an uncontrollable, fluctuating electrolyte picture, particularly in the presence of a good or only moderately depressed volumetric urinary output. If these abnormalities can not be controlled by parenteral fluids there is little offered by dialysis. Furthermore, hemodialysis in the presence of an anemia with less than 8 gms. of hemoglobin, greatly increases the inherent risk of dialysis. Again, hemodialysis is not the entire answer to the problem of renal dysfunction or electrolyte imbalance, but serves only as one of several therapeutic instruments.

The artificial kidney has little to offer the patient suffering with chronic renal disease except possibly for the occasional situation in which there is an acute exacerbation of a chronic condition. The use of the artificial kidney in this situation depends upon whether or not it is thought that if this acute period should be bridged the patient might reestablish sufficient renal function to permit life for a variable period of time.

Dialysis may also provide a means of balancing a patient's electrolyte pattern prior to surgery when an operative procedure will materially benefit renal function. A relatively normal preoperative electrolyte picture may mean the difference between a successful and unsuccessful post-operative course. Obviously these situations will be rare, but they are worthy of mention.

Summary

The principles and management governing the immediate therapy of acute reversible renal dysfunction are outlined.

The indications and limitations of hemodialysis and ultrafiltration are briefly discussed.

How Would You Examine The Colon?*

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IT IS, or should, be the aim of every doctor to make an early diagnosis; when this is correctly established, the proper treatment frequently follows easily.

I am writing not as a specialist whose attention and interests are focused solely on the eradication of lesions at the outlet of the digestive tract, but as a physician whose concern it is to see more sick people restored to health.

As physicians we must remember that whatever the region of our special interest, it constitutes only a part that is by no means a separate entity, but is intimately united structurally and integrated functionally with every other part of the whole organism. Furthermore, we can never forget that the patients we treat are not merely bodies with disease but living human beings with individual and various emotional temperaments and minds and that they react in very different ways. It is increasingly significant that we must consider this interdependence of mind and body in interpreting the significance of any symptom or lesion.

What part of the body is more prone to functional disease than the gastrointestinal tract?

Where do the symptoms of the constitutional inadequate most often land?

What is gained by removing hemorrhoids just because hemorrhoids are present in such an individual?

Progress in Education

In recent years, there has been an increasing interest in the use of the sigmoidoscope. It is gratifying to find that many are now including a sigmoidoscopic examination as a part of the complete physicial examination. Still only an occasional candidate for life insurance is examined so thoroughly. On the other hand, many larger companies who give some or all of their employees the benefits of periodical physical examinations are insisting on the inclusion of a sigmoidoscopic exam, in the over-all examination.

The average patient is rapidly losing hesitancy to have the anus or lower colon examined.

Great strides have been made in the education of the public towards the detection of cancer. I fear at times that the patients may be ahead of us. They have been told and have read that change in bowel habit and/or bleeding from the bowel should be investigated. I hope that enough of us are ready and able to provide that careful examination that they think they are going to get or should expect.

If we are ever going to prevent cancer of the colon, we must search for and recognize the benign precancerous polyp in the colon. They are frequently too small to cause symptoms and frequently can't be demonstrated in radiographic studies.

The detection of cases of ulcerative colitis and familial polyposis also makes this examination advisable.

Sigmoidoscopic Yield

A sigmoidoscopic examination is an office procedure, and, of all the endoscopic studies, it is the most productive examination in the cancer prevention program. One hundred per cent of all cancers of the rectum can be diagnosed by sigmoidoscopy. Approximately 85 per cent of the cancers of the whole colon can be diagnosed by sigmoidoscopy. Cancer of the rectum and lower sigmoid which as a rule requires such mutilating surgery for an attempted cure could be made a rare disease indeed if more routine sigmoidoscopic examinations were done to find the usually asymptomatic premalignant adenoma.

It is frequently heard, or read, that a sigmoidoscopic examination should be done if

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this or that symptom or sign is present.

The fact should be emphasized that, perhaps leaving out the pediatric level, the indication for a sigmoidoscope examination should be a patient to perform it on.

It was mentioned previously that 85 per cent of the cancers of the colon can be visualized with a 25 cm. sigmoidoscope. Approximately 85 per cent of adenomatous polyps are within reach of the 25 cm. sigmoidoscope. These like percentages are probably more than coincidental.

The frequency of finding a premalignant or a malignant lesion with the 25 cm. sigmoidoscope varies with different observers. The incidence varies from 7 per cent to 14 per cent. It is the experience of the writer that approximately 11-12 per cent of the patients whom he sees have an adenoma or a carcinoma.

Let me say a word about the preparation for the use of the all-important weapons, so to speak, that are available for the thorough examination to which we all think the patient is entitled.

What one is attempting to do primarily is to make a diagnosis. If it is determined that a sigmoidoscopic examination is in order, and I hope that I have offered some proof that it is in order and highly desirable in all patients, to do so in the shortest possible time there must be some orderly procedure followed in the various parts of the examination.

Order of Examination

It would be presumptuous to dictate the order in which various systems are investigated, but when it comes to the investigation of the gastrointestinal tract, these suggestions might be timely and time saving.

The examination of the upper G.I. tract should be done after investigation of the large bowel so that the barium ingested will not interfere in examinations of the colon and its contents.

If it is thought necessary to have the stools examined microscopically, have them done before you do a digital and sigmoidoscopic examination. Either of these may cause an abrasion which might cause blood to be seen in the microscopic examination or in the chemical test and cloud the picture. If stool examinations are to be done, don't be satisfied with one. Statistically it has been shown that three stool examinations done on consecutive days will show a positive result in 95 per cent or more of the cases if there are pathogenic organisms present. It is reasonable to stop with three negatives, unless there is strong clinical evidence that something will be found.

The next step after the series of stool examinations has been done is digital examination followed by a sigmoidoscopic examination.

Now a word about the preparation of the patient for sigmoidoscopic examination. It is a great temptation if you are going to do the sigmoidoscopic yourself to do it at the time whether or not the patient's bowel has been cleaned out. Or to send him at once to a proctologist in an attempt to hurry the examination to save yourself or the patient time, saying, "He just has a little lump, or a vague symptom, and, anyhow, he says his bowels moved good today." You rarely gain anything by this. It is surmised that you want your patient to have as comfortable an examination as he can get and that you desire the best information from the examination that can be realized. This cannot be assured unless the lower bowel is clean.

For the sake of your patient's feelings and for the best examination have him take plain water enemas until the return is clear at least two hours before the attempt to scope him is made. Thus, the chances are much better that he won't be mauled about in attempting to bull your way around a lot of feces in the lower bowel, one small piece of which may hide just what you are looking for. By all means do the sigmoidoscopic examination before barium is given by mouth or introduced into the lower bowel. The introduction of barium first might hold up a properly done sigmoidoscopic for two to three days.

On the following day, after what preparation your radiologist desires, the x-ray of whatever type you want can be done. It is not well to follow a sigmoidoscopic examination by a barium study the same day. The bowel has been irritated by the passage of the scope and the bowel contains air. This will interfere with a proper x-ray evaluation. Above all, be sure that the examination will include fluoroscopic observation as well as films with the proper amount of barium in the colon. It is surprising,

but some still try to arrive at a diagnosis by films alone. It is timely here to remind you that you have very little chance of demonstrating polypoid lesions with a routine type of barium enema. The double contrast type, with meticulous preparation is imperative.

Recapitulation

To recapitulate, do the stool examinations first, if they are indicated, and get at least three negative reports. Following this, and at least 24 hours after the stool examination, because the laxative may cause mucosal changes which cause indecision, do the digital and the sigmoidoscope. The next day have the x-ray of the colon done, and if polypoid lesions are suspected, have the double contrast type done.

This orderly sequence will pay off in the long run by giving each examiner the best possible chance to do a good job.

Whatever mechanism or organization can best implement closer collaboration between and among general practitioners, medical and surgical specialists is the one that should be established. As physicians interested in advancing the care of the sick, we must recognize that the next stage in the improvement of medical care demands this cooperation and the coordination of facilities. Even without any new drugs or better methods than we now have, the practical care of patients could be much improved if combined knowledge were made more generally available.

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The Significance Of Rectal Bleeding*

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BLOOD passing per rectum is such a common occurrence that it too often receives little or no attention. In most instances it is caused by anal abrasions, small internal hemorrhoids or some other relatively minor anorectal lesion and should occasion no great apprehension. Not infrequently, however, it is the first and only early indication of a more serious disorder of the alimentary tract. Often it is only after a careful history and thorough physical examination that the cause and source of rectal bleeding is ascertained. To assume the source of bleeding is hemorrhoids without making a thorough examination to exclude a more serious lesion may lead to disastrous consequences. It is imperative, therefore, to determine accurately the bleeding source without undue delay and before definitive treatment is begun in order to avoid such pitfalls. The difficulty encountered in operating on a patient with alimentary tract hemorrhage, but without more specific localization, is well recognized and often fraught with failure.

Characteristics of Rectal Bleeding

The blood may be evident by gross examination or it may be occult in type and discovered only by microscopic or chemical examination. Either type may come from a lesion involving any portion of the alimentary tract from the esophagus to the anus. Usually, if the bleeding is in the upper portion of the alimentary canal, the blood is so changed by the time it passes per rectum that it is not recognized as such; whereas, if the source is the lower part of the canal, it will have the appearance of fresh blood. Not infrequently, however the appearance of the blood is not an accurate indication of its source. Blood from the esophagus may pass through the gastrointestinal tract so quickly as to appear almost fresh. Conversely, bleeding from an internal hemorrhoid may be retained in the rectum long enough to appear dark and old when passed.

If the blood is mixed with the stool, its source is most likely above the left half of the colon; whereas, if streaked on the stool or separate, it is from below that level. Bleeding from the anal canal usually follows defecation and is often observed on the toilet tissue.

Causes of Rectal Bleeding

Undoubtedly, the most common cause is a group of anorectal disorders such as anal abrasion, internal hemorrhoids and anal fissure. These conditions are easily identified by inspection of the anus and lower rectum through an anoscope with the aid of a good light. They cannot be detected by digital examination alone. Before undertaking treatment of these disorders a proctosigmoidoscopic examination should be made to exclude the possibility of a more serious coexisting lesion higher up which may be really the source of the bleeding.

Tumors of the gastrointestinal tract are the next common cause of rectal bleeding. They occur most often in the colon and rectum. They may be either benign or malignant. The most common benign tumors are adenomatous polypi which are of interest not only because they bleed, but chiefly because they may undergo pathologic change resulting in the most common malignant tumor — adenocarcinoma. Consequently, it may be lifesaving to identify and eradicate rectal or colonic polypi.

Rectal bleeding is often the only clue to the presence of a tumor involving the colon and rectum. Proof of the presence of such a lesion is obtained by the following diagnostic measures made in the order named:

1. *Digital Examination.*
   Most tumors of the rectum can be felt.
2. *Proctosigmoidoscopic Examination.*
   Approximately 70 per cent of tumors in-

*Presented at the Postgraduate Medical Seminar of the Norton Memorial Infirmary on December 18, 1958.

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volving the colon and rectum can be seen by this measure. At the same time the tumor may be removed if pedunculated or a biopsy taken if removal is not feasible.

3. *X-ray Examination After Barium Enema.* By this means tumors of the colon, above the level reached with the sigmoidoscope, are identified with a high degree of accuracy by those well trained in its use.

Bleeding is often associated with inflammatory diseases of the gastrointestinal tract, one of the most common of which is ulcerative colitis. The blood is usually mixed with mucus and stool and may be slight or large in amount. Occasionally, the bleeding will be almost exsanguinating in severity. Bacillary and amoebic dysentery, typhoid, regional enteritis and diverticulitis may cause bleeding similar to that in ulcerative colitis.

Massive bleeding is usually caused by peptic ulceration of the gastrointestinal tract, including that occasionally associated with a Meckel's diverticulum. Severe bleeding may also occur from ruptured esophageal varices and mesenteric thrombosis.

The passing of blood and mucus with the appearance of currant jelly is commonly associated with intussusception. Rectal bleeding may be the only indication of trauma involving the lower intestinal tract. Bleeding following anorectal surgery and following sloughing from injudicious use of hemorrhoidal injections may be severe. Factitial proctitis, a complication from irradiation of the cervix with inadequate screening, is not uncommon as a cause of bleeding.

Summary

Although in most instances rectal bleeding may indicate some relatively minor anorectal disorder, it is always of sufficient significance to warrant a thorough investigation of the entire alimentary tract, if necessary, to determine its source. It is imperative to have the source of bleeding accurately identified before undertaking its treatment.

Make Your Plans Now

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KSMA ANNUAL MEETING

Sept. 22-24

Cough*

John S. Harter, M.D.**

Louisville, Ky.

THE diagnosis of the cause of cough is necessary in order to treat cough. In my opinion there is no cough syrup or other cough medicine of any value. If cough medicines were of any value, many more bronchiogenic carcinomas, heart failures, bronchiectasis, et cetera, would go unrecognized much longer than at present.

Causes

Cough is a protective mechanism. The attempt of the body to get rid of a foreign matter is the prime cause of cough.

Probably the most unusual cause of cough is wax in the external auditory meatus. This is simply due to irritation of the vagus nerve, as are all cough mechanisms. Mucus, pus, bronchiogenic carcinoma, et cetera, all irritate vagus nerve ends, causing cough, just the same as a foreign body.

The tickling in the throat that occurs just before most people cough is the referred symptom of a foreign body in the tracheobronchial tree. People with dry cough usually have accumulation of mucus in the tracheobronchial tree which is coughed up in such small amounts that they are not conscious of sputum. Most of the cough syrups are designed to alleviate the tickling of the throat which, of course, has nothing to do with the cause of the cough.

A brief history, physical examination and an x-ray of the chest will usually lead one to a correct diagnosis of the cause of the cough for which the patient came to you for relief.

Cough is not ordinarily caused by sinusitis, postnasal drip and tonsillitis. Correction of these conditions is, of course, necessary, but not under the guise of the treatment of cough.

Probably the most common cause of cough is the acute upper respiratory infection known as the common cold. This is a virus infection, is self-limited, and at present there are no antibiotics of any value in its treatment. Cold vaccines are made of organisms cultured from people with common colds. They are not the cause of colds, yet a whole group of these organisms, including the pneumococcus, catarrhalis, and streptococcus are put together, killed by one fashion or another, and used as vaccines, which they are not, to cause immunity to a disease, the common cold, which itself does not cause immunity. Antibiotics will prevent possible complications of the common cold but do not have effect on the common cold. Time alone will take care of the common cold. Usually the cough will disappear in a few days whether it is treated or not.

Another common cause of cough is, of course, smoking. Smoking paralyzes the ciliary removal of mucus from the lungs. Therefore, in order to get rid of the mucus it is necessary to cough. This condition can be helped by thinning the mucus with an expectorant such as ammonium chloride, but the cure is to stop smoking, and no amount of treatment other than the discontinuance of smoking will cure these individuals. The older individual with emphysema who has poor drainage of the mucus from his lungs, due to the decreased motion of the bronchioles and smaller bronchii, as well as stratification of the columnar epithelium and loss of cilia, finds it impossible to smoke. Most individuals in the fifties and above who arise in the mornings to a fit of coughing and the production of large amounts of clear mucus have emphysematous bronchitis aggravated by smoking and will only respond to treatment after smoking has been discontinued. As a rule these people do not have bronchiectasis.

Treatment

At times patients will be found resistant to the ordinary types of medication. Most of these individuals can be helped by the use of one of the high alcohols, such as Alevaire®, to liquefy the mucus along with a bronchial dilator, such

*Presented at the Postgraduate Medical Seminar of the Norton Memorial Infirmary on December 18, 1958.

**Associate Professor of Surgery and Chief of the Section on Thoracic Surgery, University of Louisville, School of Medicine.

as Isuprel®. In order to get these materials into the terminal bronchioles, it is necessary to use an atomizer that develops an extremely finely divided mist. In order to get this mist into the terminal bronchioles positive pressure is necessary. Machines have been devised to give intermittent positive pressure breathing. Many cases of resistant bronchitis will respond to this type of therapy.

Purulent bronchitis may occasionally occur. It is particularly resistant to treatment in the emphysematous individual. Antibiotics are of value in its treatment, but the dose must be greatly increased over that ordinarily used in diseases, such as pneumonia. Expectorants, as ammonium chloride, are of value along with the antibiotic.

Bronchiectasis is a disease of younger individuals and is rarely found after the age of fifty. The patient with the wet type of bronchiectasis coughs up varying amounts of purulent sputum, usually for years before seeing the doctor. Treatment with antibiotics is only of temporary help and removal of the bronchiectatic areas is mandatory for cure of the cough and expectoration and to prevent spread of the disease within the lung. Dry bronchiectasis may be asymptomatic except for bouts of hemoptysis. The only way bronchiectasis can be diagnosed is by doing a bronchogram.

Bronchiogenic carcinoma, a not unusual cause of cough, will usually show changes on the x-ray of the chest. Unfortunately, many of these x-rays are misread as localized pneumonias or unresolving pneumonias and the optimum time for treatment is lost because of misinterpretation of the roentgenograms of the chest.

Wheezing as an accompaniment of cough is frequently seen in the smoker's chest, as well as allergic individuals, and is not uncommon in bronchiogenic carcinoma. It also occurs with foreign bodies in the tracheobronchial tree.

Cough is a common sign of early heart failure. This is due to the accumulation of fluid in the periphery of the lung and, of course, is cured by the proper treatment of the heart failure.

Summary

In summary, the treatment of cough consists of a proper diagnosis and the institution of therapy to remove the cause of the cough. If the sputum is mucoid, do not give antibiotics but most give an expectorant, such as ammonium chloride. This must be given in doses of at least six grams a day in the average sized adult. Iodine if given in large enough doses is of value but people cannot tolerate sufficient iodine to act as a good expectorant.

If the sputum is purulent, it is wise to do a bronchogram to rule out bronchiectasis before starting on a course of large doses of antibiotics. The treatment of cough in people who smoke will not succeed until the patient cooperates sufficiently to stop smoking.

Every individual who is coughing should raise in your mind the possibility of a bronchiogenic carcinoma being present. If bronchiogenic carcinoma is considered in each individual as a possibility, many more of these individuals will be obtained for surgery in time for cure.

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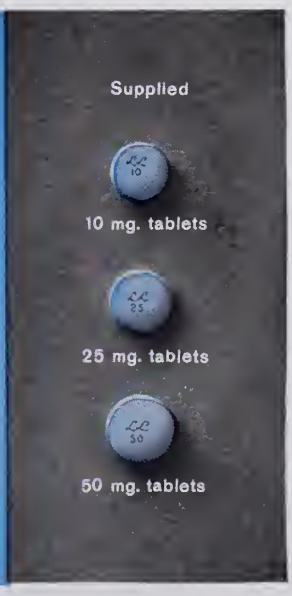
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CASE DISCUSSIONS
From The
University of Louisville Hospitals

Norton Psychiatric Clinic

Treatment of Chronic Alcoholic Intoxication Complicated by Bromide Intoxication and Subdural Hematoma

PRESENTED BY: E. E. Landis, M.D., Professor of Psychiatry, University of Louisville School of Medicine; Medical Director, Norton Psychiatric Clinic.

PD, a 42-year-old white married female was transferred to the Clinic on February 28, 1958 from the Norton Medical Service following consultation for "delirious episodes occurring more acutely at night following excessive use of alcohol." Consultation revealed confused thinking, attempting to climb out of bed at times and tendency toward noisiness making it impossible to take care of her on a medical ward.

At the time of her admission she appeared sedated with the odor of paraldehyde on her breath, able to respond to verbal stimuli, seemed to comprehend questions but also at times was confused and disoriented. Her temperature was 99°, pulse 84, respiration 18, and blood pressure 180/130. When more history could be obtained from family, there was a story of twenty years of limited alcoholic intake socially with a marked increase during the past six months causing serious problems around the holiday season. Relatives complained of patient's sleeplessness, headache, and unpredictable moods with considerable irritability.

Family history indicated that both parents were incapacitated, father being paralyzed by cerebral accident and mother recently having a cerebral accident. Personal history reveals that the patient was reared in luxury with one sister, having little parental attention but full-time care by a nurse. She was intelligent, made better than average grades in school, and was quite active in athletics and sports. In general her behavior was that of a popular, attractive girl. During high school period the family suffered financial reverses and patient married shortly thereafter. In marriage there developed tensions and insecurities to which the patient reacted strongly. Patient has always revealed a responsive, affectionate personality, however in the face of lack of sufficient security in her homelife and increasing responsibility she turned to the use of alcohol for relief.

In the hospital during the first twenty-four hours of patient's confusion and transitory periods of coma, it became apparent that she might be suffering from something other than a simple delirium and probably had a grand mal seizure. Within twenty-four hours after admission there was evident some suggestion of excessive nuchal rigidity and left hemiparesis. Pupils were round, equal and reacted briskly to light but the fundi could not be visualized because of congenital cataracts. There was some suggestion of left lower facial weakness, all deep reflexes being hypoactive and there was a definite left Babinski. More detailed information revealed a "minor fall, February 15, with a small bruise on head."

An EEG was very dysrhythmic with a suggestive slow wave focus in the right temporal region and a suggestive decrease in amplitude in the right temporal region. X-rays of the skull revealed no evidence of fracture and the sella appeared to be normal and no shift of the

pineal gland was seen because of lack of calcification.

Shortly after the above examination the patient was awake, answered questions, but was disoriented. She could move her left extremities quite well. A spinal puncture was done revealing an initial pressure of 300 mm. of water—clear, colorless fluid. The final pressure after removal of 6 cc. was 140 mm. of water. The fluid contained one lymphocyte with a total protein of 54.6 mg.%. Within a half hour the patient was quite alert and the left hemiparesis had completely cleared. By the next morning the patient was quite alert, confabulating some and facetious, without focal neurological signs other than a suggestion of left lower facial weakness. At this time there were considered diagnostically toxic conditions with epileptic seizure, Korsakoff's syndrome, subdural hematoma or possible brain tumor as well as some of the meningitides or vascular and metabolic diseases.

Blood examination on March 1, 1958 revealed red count 5,217,000; white count 17,400; 89 neutrophiles; 1 basophile; 6 monocytes; and 4 lymphocytes. Urine was essentially negative. Blood bromide on March 4, 1958 was 66.5 mg.% (probably higher earlier). Repeat of EEG on March 10, 1958 was still dysrhythmic but still improved over that one on March 1, 1958.

During this period the neurologist and surgeon collaborated. Patient was started on anticonvulsive medication and following lowering of the bromide level the patient became ambulatory with improved appetite and sleeping well. However, mental symptoms associated with Korsakoff-like behavior, occasional episodes of confusion and intellectual impairment led to the decision for pneumoencephalogram on April 5, 1958. This revealed a marked shift in the ventricular system from left to right indicating a large mass over the left hemisphere.

A craniotomy was performed following the making of a burr hole. A markedly organized subdural hematoma approximately 2 cm. in thickness was removed. Post-operative course was quite satisfactory until five days later there was a rather sudden onset of aphasia and later dysphasia with dizzy spells and diplopia. A recurrence of the hematoma was suspected. Carotid arteriography was done on April 15, 1958 and re-exploration on April 16, 1958 showed an epidural clot which was removed. Following this reopening with temporary drainage patient made an uneventful recovery.

Subsequent psychological examination pointed toward increasing intellectual functioning and improvement in personality integration. Throughout this treatment a great deal of help was necessary in relation to many marital problems. Having lived through this illness together both husband and wife found a closeness which had not existed for years and re-established a healthy homelife.

Discussion

Ludwig H. Segerberg, M.D.; Associate Professor of Neurosurgery, University of Louisville School of Medicine: There were several problems presented in this particular patient which obscured to a certain extent the final diagnosis. She had been an alcoholic of some considerable duration, and it is true that she had had a mild injury just prior to her admission. In addition, she had very likely had a grand mal seizure; and the picture that she presented on the original examination was consistent with the post ictal phenomenon occasionally seen following seizures with resulting vasospasm and even thrombosis. In view of the improvement which she subsequently showed in her conscious state and hemiparesis, such a possibility was certainly to be considered.

However, in subsequent evaluation the patient continued to show a progression of her symptomatology which made one suspicious of an intracranial space occupying lesion. Since there was some doubt as to the nature of this lesion, pneumoencephalogram was done; although it is conceded that arteriography would have been equally as effective as a diagnostic tool in this particular instance.

This patient showed a very marked improvement following the evacuation of her hematoma and has shown no evidence of difficulty since her surgery. She was last seen in a follow-up examination on April 7, 1959, at which time she had had no untoward symptoms and was doing extremely well.

Ephraim Roseman, M.D.; Professor of Neurology and Chief of Section, University of Louisville School of Medicine.

This patient represented a differential diagnostic problem of organic psychosis occurring in a relatively young person. The causes for such psychoses are not too many in number

and would include such things as:

1. Neoplastic
2. Toxic
   a. Exogenous, e.g., alcohol, both ethyl and methyl
   b. Endogenous, e.g., uremia, liver failure, etc.
3. Presenile dementias, e.g., Alzheimer's disease and Pick's disease
4. Vasular disease, which would include anything which might involve the cerebral arteries either primarily or secondarily, such as hypertension, collagen disease, diabetes, etc.
5. Metabolic diseases such as hyper- and hypo- metabolism and possibly also epilepsy.
6. Trauma with particular reference to the occurrence of chronic subdural hematomas.
7. Inflammatory, with particular reference to chronic meningitides such as infection with cryptococcosis

It behooves the clinician whenever and wherever possible to rule out treatable diseases whether they can be approached by knife or the application of some type of medication or even removal of some type of medication. Hence, it is always important to try and reach an etiologic conclusion. In the list noted above most are treatable. For example, neoplasms can be diagnosed with the aid of techniques such as arteriography, pneumography and electroencephalography. If life is to be preserved and cures are to be effected, surgery, of course, is indicated.

One of the most common group of causes of organic psychosis is the exogenous toxins in the form of ethyl alcohol. Dr. Roger Lee said "It is an old saying that alcohol is a highly inflammable substance whether you apply a match or a word to it." The psychoses seen with alcohol can be of the acute or chronic type, or the complications associated with it such as trauma need always to be suspected. Ninety-five per cent of the subdural hematomas occur in chronic alcoholics. Alcoholics obviously have a propensity for trauma; however, some investigators have determined that the vitamin content of the blood, including vitamin C, is lowered in the patient addicted to alcohol. Chronic use of alcohol may possibly lower the threshold of extravastion of blood. The mechanism is probably similar to that of a hemorrhagic extravastions in scorbutic children who likewise suffer subdural hemorrhages, as well as hemorrhages of other types on slight trauma. It can be truly said that the only sure way of making a diagnosis of subdural hematoma is to "look." By this it is meant that the bilateral insertion of burr holes in both temporal frontal regions (95% of subdural hematomas occur on the vertex of the brain). Thus a high index of suspicion is the best diagnostic way of making this diagnosis.

Concerning the endogenous toxins, uremia and chronic liver disease are the most common and can be made apparent, of course, by the appropriate chemical tests of the blood and attempts should be made to relieve the underlying causes.

The presenile dementias can only be suspected and can be further corroborated by air studies but the final diagnosis remains for autopsy or at best by biopsy specimens made during life.

The most interesting group of causes for chronic psychoses are the blood vessel diseases and with particular reference to the collagen disturbances. Collagen disease, of course, may involve any system of the body and recently it has shown to have a particular propensity for the brain. It can be said that an acute or chronic psychosis in a relatively young person needs always to be investigated for the possibility of collagen disease which, of course, would include such things as periarteritis nodosa, lupus erythematosis, dermatomyositis and scleroderma.

The metabolic disturbances such as hyperthyroidism and hypothyroidism usually can be detected by the average clinican and appropriate studies can help in its confirmation.

At the Louisville General Hospital in the past ten years we have seen about twelve cases of torulosis in which the predominant presenting symptoms were those of a psychosis. Examination of the spinal fluid with particular reference to doing an India Ink preparation and inoculation on Sabouraud's medium can help in its confirmation.

In the case of this patient, she had shown signs of a chronic psychosis for at least some four months prior to admission to the hospital with an acute episode, probably a seizure, noted on March 1, 1958 following which she

developed a left hemiparesis. Following this seizure the patient initially improved and then slowly became worse again so that by the next month, although she had been off of bromides and alcohol, she actually had shown signs of deterioration. In view of this, further investigation was certainly indicated and it was by this method that a space occupying lesion of the left side was noted and hence the diagnosis of subdural hematoma was confirmed.

It would seem to me that the lesson to be learned from this problem is that when one is dealing with an organic psychosis, particularly in a young person, and an adequate history is not available, but alcohol intake is a factor, the possibility of subdural hematoma should always be considered.

S. Spafford Ackerly, M.D.; Chairman, Department of Psychiatry, University of Louisville School of Medicine. This case demonstrates very effectively the complex nature of diagnosis in neuropsychiatric conditions in general, often parading under addiction to alcohol, barbiturates, or severe stress which can wear the person down. Interpersonal and environmental stresses that sap the patient's reserve such as Selye's stress reaction. It points up the need for comprehensive medical approach to mental conditions as seen in the general hospital where complete medical, surgical, and laboratory care are available, as well as the need for readily available consultation by psychiatric specialists and those indicated allied specialists. The clearing up of this psychosis as the patient's resistence improved and toxicity decreased in the face of an already present subdural hematoma is of interest and could easily throw one off the track temporarily. The answer here was by constantly available observation of total functioning of the patient including careful personality assessment that gave the crucial clues to indicate that this patient was still sick in spite of apparent improvement.

". . . A doctor, to be according to his name—a teacher—should be more than any other man a student of nature as well as of human nature; for, with all learning—failing the possession of the sixth sense of the Scotchman—common sense—a poor doctor is he!"

Excerpted from "Concord! or Medical Men and Manners of the Nineteenth Century." By J. V. Flannagan, 2nd Ed., Baillière, Tindall, and Cox, London, England, 1879.

SPECIAL ARTICLES

Infectious Hepatitis in Kentucky, 1958-59

PATRICIA CONLAN, M.D.* AND CHARLES KLAYER**

Louisville, Ky.

THE significance of infectious hepatitis as a public health problem is increasing rapidly. Until recently, hepatitis outbreaks had occurred mainly during times of war and natural disaster. In the past few years, however, the incidence of hepatitis has been rising in the general population. Although the number of cases reported throughout the country has decreased from a high of 49,722 in 1954 to 16,012 in 1958, hepatitis remains a serious problem in some far western states and in Kentucky.

In Kentucky, 658 cases were reported during 1958, for a case rate (number of cases per 100,000 population) of 22.1. Provisional figures show that this rate was exceeded only by Oregon (26.3), Idaho (32.6), North Dakota (38.6), Nevada (39.0), New Mexico (44.4), Montana (63.5), and Arizona (71.4). Moreover, Kentucky's rate is more than twice that of neighboring states—Tennessee has a rate of 9.3; Ohio, 8.9; West Virginia, 8.2; Virginia, 7.8; Illinois, 6.5, and Missouri and Indiana, 6.1. New Hampshire and Louisiana have the lowest rates—0.3 and 0.5 respectively. The 1958 U.S. rate is 9.2.

Hepatitis has consistently ranked 10th in number of cases among communicable diseases in Kentucky since reporting was begin in 1951, and in 1957 ranked fifth among communicable diseases causing death.

*Acting Director, Bureau of Medical Services, Kentucky State Department of Health.
**Senior Statistician, Division of Statistical Services, Kentucky State Department of Health.

During the first quarter of 1959, the case rate for Kentucky has more than doubled, increasing to 45.3 with 337 cases reported. Furthermore, the seasonal drop expected in March has not occurred. Indications are that higher than normal rates may continue throughout the year.

In order to facilitate the statewide study of infectious hepatitis, Kentucky has been divided into nine zones of approximately equal populations (see map).

The chart shows rates for the first quarter of 1958 and of 1959 compared with the State rate for the year 1958. In Zone I, there was an increase in cases reported, although the rate remained lower than the 1958 state rate.

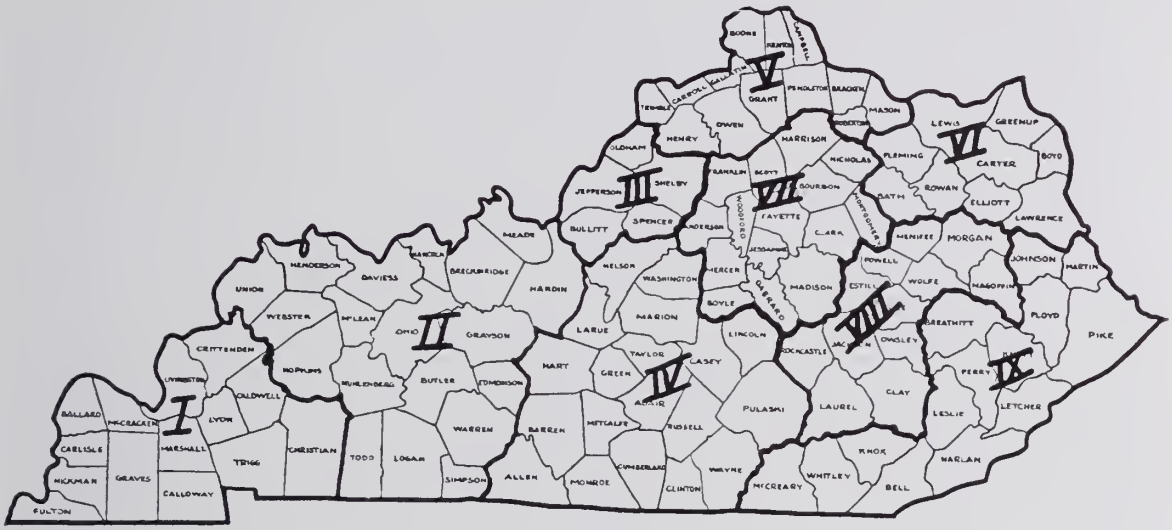
Zone II shows a decrease for the first quarter of 1959 compared to the same period for 1958, although both figures are well above the state rate.

The significant increase for the first quarter of 1959 in Zone III is essentially due to the large number of cases (99) reported from Jefferson County.

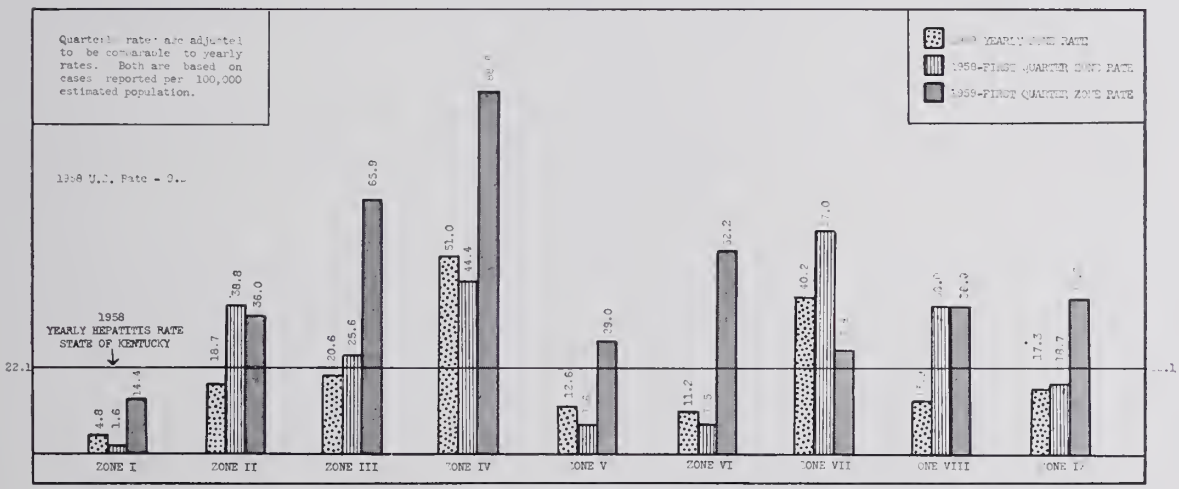
In Zone IV, the large number of cases in Wayne and Russell Counties is responsible for the unusually high case rate for the first quarter of 1959.

While the case rate for the first quarter of 1959 in Zone V is relatively low, the increase is quite noticeable due to the fact that Mason County had 12 cases in the first quarter of 1959, but none reported in 1958.

Reported Cases of Hepatitis in Kentucky by Zones 1958-59



The zones are indicated by Roman Numerals for your convenience in making comparisons.



The greatest increase during the two reported periods is in Zone VI. The case rate jumped from 7.5 to 52.2. Counties showing impressive increases were Bath, Carter, Rowan, and Lewis.

Zone VII shows a marked decrease in hepatitis, although the rate remained above the state average for 1958.

In Zone VIII, the case rates for the first quarter of both 1958 and 1959 are the same. It will be interesting to see how the 1959 zone case rate will compare with the 1958 zone rate of 13.9.

Zone IX's increase in early 1959 was due mainly to increased cases in Harlan County.

From 1952 through 1956, hepatitis was concentrated in the western and central portions of Kentucky, with a serious outbreak occurring in Calloway County in 1954. Since 1956, however, the disease has spread statewide.

Significant outbreaks have occurred in Bath, Harlan, Henderson, Jefferson, Jessamine, Lewis, Logan, Mason, Ohio, Pike, Rowan, and Wayne Counties. Kentucky State Department of Health epidemiologists have investigated most of these outbreaks, assisted in some instances by U.S. Public Health Service epidemiologists. Possible sources of infection, dates of onset, and contacts of patients with hepatitis are being investigated with the hope of eliminating the focus of infection. In schools where outbreaks occurred in Henderson, Jefferson, and Lewis Counties, sanitary measures to alleviate conditions contributing to the problem have been instituted. In the other counties, a common source of infection could not be found —it is assumed that the disease was spread from person to person.

The investigators visited as many reported cases as possible, and by checking contacts of these patients discovered many cases which had been previously unreported. In Wayne County, cases that were not frankly jaundiced were checked for leptospirosis and infectious mononucleosis.

Except for the fact that the seasonal drop has not occurred, Kentucky's hepatitis cases follow the general pattern of hepatitis throughout the country. Of the 658 cases in 1958, 152 were among children aged five to nine, and 101 were among children from ten to 14. These totals are from two to three times the number of cases for the next highest age group.

The incidence of jaundice increased directly with age in Kentucky, as has been the usual experience in the United States. The number of cases of hepatitis among Negroes is negligible compared to cases among whites—only ten of the 658 cases in 1958 were Negro.

There have been large numbers of cases in urban areas, where lower rates might be expected because of improvements in sanitation. This might suggest, however, that although insanitary environment is a factor, low personal hygiene standards play a larger part in the spread of hepatitis.

Until an effective vaccine can be produced, Kentucky physicians should continue inoculating household contacts with immune globulin, dosage being 0.01 cc per pound of body weight.

The State Health Department is maintaining a constant surveillance program on infectious hepatitis in Kentucky. A study to determine if there is a connection between hepatitis and chronic liver disease is being contemplated.

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The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

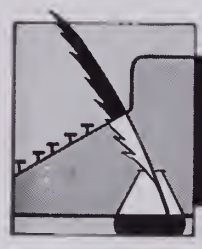
When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

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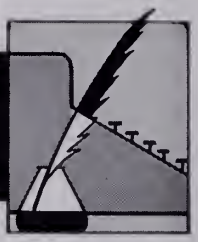
G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

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*Brown, S. S.; Libo, H. W., and Nussboum, A. H.: Norethondrolone in the Successful Management of Anorexio and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.



EDITORIALS



Medical Missionary Effort

THE average doctor in America today stands on the pinnacle of medical attainment of all times. He enjoys the benefits of better training, better hospitals in which to work and more effective tools with which to treat disease. In keeping with the rest of American society, he makes more money, spends more money, has a larger home, eats better food and drives bigger and faster cars than most of his fellow physicians in other countries.

His chief concerns are such items as socialized medicine, third party medicine and prepayment medical insurance schemes of one type or another. It is interesting to note that much of his time and effort outside his office are devoted to pursuits and problems that have to do with maintaining his economic position or bettering the same. Of course, there are post graduate courses for improving his technical ability, but in the fierce competition of American medicine, the doctor who is best trained and who keeps abreast of developments will probably profit the most financially.

This past summer it was my privilege to be a member of a team of six doctors who were sent to visit medical mission installations in Asia and Africa. The team members were of several different denominations but went out under the sponsorship of the Baptist World Alliance. There were sixteen in the party, including, besides the doctors, the medical news writer of the *Cleveland Plain Dealer* and two photographers. Throughout the trip we distributed over $100,000 worth of drugs and supplies donated by American surgical, supply and pharmaceutical firms. We visited Catholic, Presbyterian, Methodist, Baptist, Seventh Day Adventist and inter-denominational cooperatives as well as Buddhist, Moslem, Hindu and native government hospitals.

I am sure that there were none of us on the team who had not at some time or the other read about many of the places that we visited and, yet, I feel safe in saying that ninety plus per cent of the time, we were shocked and amazed at what we saw. There is not space here to describe a trip of over three months seeing so many different places. Allow me to briefly outline a few of our conclusions.

We, physicians, along with our fellow Americans, are living in a fool's paradise. The vast majority of the peoples of the world outside of the United States do not have available to them the degree of medical care available in America fifty years ago. There are places where the era of antibiotics has not arrived. Everywhere, we saw diseases that we had never seen except in text books.

It was further impressed upon us that due to increasing improvements in communications, as well as other factors, these people are no longer satisfied to receive under par medical care any more than they are satisfied with being dominated by colonial systems or being starved because of lack of food. We came home convinced that America has done very little to help these people. Oh, we have spent millions of dollars in some countries. We have scratched the surface here and there, but in the majority of cases only where it would buy us air bases or some other commercial concession. We have all felt that we could buy our friends.

This line of thought seems incomphrensible in the only nation on earth that was founded on faith in God. We can help these people of the world only if we go to them in love. Interestingly enough, there exists already a set-up and channel through which this can be done.

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

I refer to the medical mission hospitals, scattered throughout the world, except perhaps behind the Iron Curtain. These outposts of American medicine occupy a very vital position in the lands where we found them. Universally, they are appreciated, welcomed and accepted. As a matter of fact, we found them requested and invited into areas that were completely closed to purely evangelistic Christianity. We found ourselves welcomed by Moslems, Hindu, Buddhists doctors and government officials alike. These people know Western medicine. They are acquainted with it's advances. We were invited to send more doctors to help almost any time, anywhere that they could be made available. (There was a single unique exception in the Union of South Africa where apparently only Afrikaners (Dutch) are welcomed in any field).

You will be happy to know that the medical mission doctor is in the vast majority of instances well trained like yourself. He differs from us only in that actually he represents only the best of us. We found these medical mission doctors free from many of the problems that beset us, free of many of the tensions and worries. After all, they are men with a mission. They know for what they stand and where they are going. There are few ulcers, coronaries, or nervous breakdowns among them. They are a well-adjusted group, dedicated to serving God and, as one told me, showing Christian love through the practice of medicine.

Some years ago, Elmer Hess, M.D., then President of the American Medical Association, told a St. Louis Medical Meeting that the American doctor was in trouble because he had quit taking God into the sick room with him. The American mission doctor, interestingly enough, takes God with him wherever he goes every day. Could this be the real challenge to American medicine? Could doctors succeed where politicians and statesmen fail? Do we comprehend the world need? We can see the framework, the skeletal force, manned by the missionary doctor, on which the best in medical care and our love and concern for people can be taken to them. What is missing? Simply you. The workers? Yes. The money? Yes. The drugs? Yes. We didn't visit a station that didn't need much more than it had, that didn't have many, many more patients than it could take care of, too few nurses, almost no medical technicians. They laughed when we talked about doctor shortage and nurse shortage in America. In Indonesia there is one doctor to every 170,000 people. What will you do? What can you do to help your fellow doctor, maybe your old classmate? It really should interest you very deeply either from the standpoint of practicing medicine with the love of the Great Physician or else just doing what you can to save this world, civilization and your own skin in this Atomic Age in which we live.

Gabe A. Payne, Jr., M.D.

Brighter Days Ahead

IT is May 30th. This day in 1951 the Council of the State Medical Association spent in session to consider the best means of expanding and improving Medical Education in Kentucky. That planning is approaching fruition more rapidly than we then anticipated. The new Medical Science Building at the University of Kentucky is nearing completion. A bond issue which would have provided for construction of the first unit of the New Medical Science building at the University of Louisville failed to pass last fall, but a drive for private funds for that purpose is in the final stage of success and this facility will be under construction before the end of this year.

In September, 1960 the first Freshman Medical Class of 40 students will enter the new school at Lexington, and for the first time in nearly 50 years as many as 140 Freshmen Medical Students will be able to begin their studies in Kentucky schools. This number will increase as rapidly as possible to 175 annually. For the first time in this generation we may encourage promising candidates to apply for admission to medical school with reasonable assurance that, if up to standard, we will have a place for them.

This evolution would not have been possible had we been without medical leaders of vision,

industry and patience. Chief among these was our beloved John Walker Moore, M.D., who as Dean carried, almost alone, the heavy load during the long depression and hectic war years, when not only the accreditation but the very existence of our medical school was threatened by lack of financial support. It was he who applied for and obtained financial aid from the state for the first time in the school's history. This has continued in substantially increasing amounts and we have the pledge of the present governor and of those elegible for election this year that this aid will not be curtailed, but increased.

Following in the fine tradition of his predecessor, J. Murray Kinsman, M.D., has proved himself an able and effective Dean. Additions and improvements in the teaching staff have been accomplished every year. Physical equipment and facilities have been improved steadily and with the present impetus will be greatly enhanced in the years immediately ahead. Research has been expanded unbelievably, even in the limited quarters available and will be amply provided for with the planned expansion.

Few appreciate the position of national prominence Doctor Kinsman has attained. He is a Regent of the American College of Physicians and serves on a number of its important policy making committees. He is currently President of the Educational Council for Foreign medical graduates and Treasurer of the Association of Medical Colleges. He is a member of the Association of American Physicians, the Central Society for Clinical Research and other National Societies concerned with teaching and research. On more than one occasion the Senior Medical class has elected him the outstanding clinical teacher of the year on our Faculty.

John S. Chambers, M.D., dreamed of and planned for years a new medical school at Lexington as a part of the University of Kentucky. It was very largely upon his tireless research and reports over more than 25 years that the need for this school was impressed upon the minds of those in authority and its establishment was accomplished.

William R. Willard, M.D., came from the deanship of the University of Syracuse to assume the same position in the medical school of the University of Kentucky. He was the number one choice for this post and we felt fortunate that he accepted. He has shown resourcefulness and vision in planning for our new school and recruiting a faculty. He has sought to adapt his thinking and plans to the needs of Kentucky and in so doing has found cordial acceptance among Kentucky physicians and leaders outside our profession.

There lies much ahead to be accomplished in the business of medical education in Kentucky but we have made a fine start. The planning has been sound. We are fortunate in our leadership. The loyalty, understanding and cooperation of all is needed now if we are to make our new and expanded facilities pay the dividends for which they were created.

Sam A. Overstreet, M.D.

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ORGANIZATION SECTION

Annual Meeting Guest Speakers Announced by Dr. Robertson

Five specialty groups recently announced their guest speakers for the general session of the 1959 Annual Meeting on September 22, 23, and 24, according to Robert W. Robertson, M.D., Paducah, KSMA president and chairman of the Committee on Scientific Assembly and Arrangements.

Biographical information on guests of the Kentucky Society of Pathologists, Kentucky Public Health Physicians, Kentucky Eye, Ear, Nose, and Throat Society, Kentucky Chapter, American Academy of Pediatrics, and Kentucky Chapter, American College of Chest Physicians, was received after the press date for the May issue of the Journal.

Frank P. Cleveland, M.D., Cincinnati, associate professor of Forensic Pathology at the University of Cincinnati College of Medicine, will speak on "Forensic Pathology, the Function and Responsibility of the Coroner's Office" during the general session on Wednesday, September 23, at 9:20 a.m. Guest of the Kentucky Society of Pathologists, Doctor Cleveland is also assistant coroner and pathologist for the coroner of Hamilton County, Ohio. He is a graduate of the University of Pittsburgh School of Medicine in 1944.



Dr. Cleveland

John R. Heller, M.D., Bethesda, Md., director of the National Cancer Institute, will be the guest of the Kentucky Public Health Physicians. A graduate of Emory University School of Medicine in 1929, he will speak on "Cancer Control" on the closing day of the meeting at 2:20. Doctor Heller was appointed assistant surgeon general, U.S. Public Health Service in 1957. He is a director-at-large of the American Cancer Society.



Dr. Heller

"Diagnosis and Treatment of Red Eye" will be the topic of John H. King, M.D., Washington, D. C., who will present his subject with a movie at 4:10 p.m. on Wednesday, September 23. Doctor King will be the guest of the Kentucky Eye, Ear, Nose and Throat Society. A Diplomate of the American Board of Ophthalmology, he graduated in medicine at Georgetown University in 1934. He is a fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology.



Dr. King

Herbert Sloan, M.D., Ann Arbor, Mich., will be the guest of the Kentucky Chapter, American College of Chest Physicians. His topic at the general session on the opening day of the meeting at 9:20 a.m. will be "Thoracic Emergencies in Infancy and Childhood." Doctor Sloan is associate professor of surgery at the University of Michigan. A graduate of Johns Hopkins University in 1940, he became board certified in surgery in 1948 and thoracic surgery in 1950.



Dr. Sloan

"Evaluation of Growth and Development in Children," will be the subject of Nelson K. Ordway, M.D., New Haven, Conn., who will represent the Kentucky Chapter, American Academy of Pediatrics, on the general program. Doctor Ordway is professor of pediatrics, Yale University School of Medicine. He graduated from Yale with an M.D. degree in 1938. Doctor Ordway was certified by the



Dr. Ordway



Honored for their service in rural Kentucky communities four former recipients and their wives attended the meeting of the Board of Trustees of Rural Kentucky Medical as special guests. From left to right are—Joe T. Pettey, M.D., Russell Springs; Carson E. Crabtree, M.D., Buffalo; William G. Edds, M.D., Calhoun; C. C. Howard, M.D., Glasgow, chairman of the Board; and James M. Tulloh, M.D., Central City. Also invited, but unable to attend was, Robert Cornett, M.D., Jackson.

American Board of Pediatrics in 1953, and is a member of the editorial board of "Pediatrics." He will speak on Wednesday, September 23 at 9:20 a.m.

All five speakers will also participate in their respective specialty group sessions, which will be held either on Tuesday afternoon or Thursday morning.

Twenty Receive First Loans from Scholarship Fund

Twenty freshman and sophomore medical students were accepted for first-year loans under the KSMA's Rural Kentucky Medical Scholarship Fund at a meeting of the Board on May 21, according to C. C. Howard, M.D., Glasgow, who was re-elected Board chairman.

This brings the total of those having received loans under the program to 187. Freshmen receiving loans were from: University of Louisville School of Medicine (10), George Washington University School of Medicine (1), University of Cincinnati College of Medicine (1); University of Tennessee College of Medicine (2), Vanderbilt University School of Medicine (1). Five University of Louisville sophomores were accepted for first year loans.

Forty-eight former fund recipients are now in practice in rural Kentucky areas—23 of this number have fulfilled their moral obligation to the Fund and 25 are in the process of doing so. Seventy-nine are in medical school or taking internship training. Twelve recipients are now in the armed forces and 7 have practiced in rural areas and have completed their obligation; and 4 are currently completing specialty training. Only 3 left rural areas before completing any part of their moral obligation and 2 are now practicing who did not live up to any part of moral obligation. Guests at the meeting were four former recipients of the fund and their wives.

During the meeting the critical need for specialists in certain areas was discussed. The Board voted to approve one recipient each year for training in a specialty that would supplement rural area general practice.

A recommendation that Owsley County be substituted for Cumberland as one of the ten most critical counties was accepted by the Board. The ten counties most critically in need of medical care are: Jackson, Magoffin, Martin, Elliott, Knott, Breathitt, Leslie, Knox, Powell, and Owsley.

KSMA Members Invited to Attend Open Meeting of Council

An opportunity to see the workings of the KSMA's interim policy making body—the Council—will be offered to members when the Council holds its annual open meeting on July 30 in the South Room of the Brown Hotel in Louisville.

Garnett J. Sweeney, M.D., Liberty, chairman of the KSMA Council, invites all interested KSMA members to attend the meeting.

The first open meeting of the Council was held in 1958. The decision to hold an open meeting of the Council each year was made by the House at the recommendation of the 1957 president, Richard R. Slucher, M.D., Buechel.

Big Sandy Seminar Program Announced by Dr. Archer

Program for the Kentucky Academy of General Practice's Big Sandy Seminar at the Paintsville Country Club, Paintsville, on Thursday, July 16, has been announced by James W. Archer, M.D., Paintsville, chairman.

Following is the program, which has been approved for four hours of Category 1 credit for members of the Academy.

1:00 Invocation and Welcome

2:00 "Some Aspects of Oral Enzyme Therapy in General Practice," Meryl M. Fenton, M.D., Detroit, Mich.

3:00 "Hypertension Therapy and Use of Antihypertensive Agents in General Practice," Albert N. Brest, M.D., Philadelphia, Pa.

4:00 Intermission

4:15 "Low Back Pain," Everett G. Grantham, M.D., Louisville, Ky.

5:15 "Alcoholism," Donald W. Brodie, M.D., Indianapolis, Ind.

6:15 Social Hour

7:30 Dinner

"Third Party Medicine in Northern West Virginia," Seigle W. Parks, M.D., Fairmont, West Va.

Wives are invited and will hear a talk by the Rev. Harold Dorsey on "Experiences While Living with a Doctor in Japan." The 18-hole Paintsville Country Club will be available at no cost to physicians and wives attending the seminar on July 15-16.

Drs. Moore and Reardon Elected

Frank H. Moore, M.D., Bowling Green, was elected president of the Kentucky Heart Association and Marc J. Reardon, M.D., Covington, was elected first vice president at a meeting of the group in Louisville on June 11 at the 10th anniversary meeting of the KHA at the Brown Hotel in Louisville.



Eighteen of the twenty recipients of first year loans from the Rural Kentucky Medical Scholarship Fund for 1959-60 gathered for a picture following a meeting of the Board. Bottom Row—(left to right)—James Crase, Gordon; Harold K. Mines, Georgetown; Robert H. Hyde, Louisville; William T. Moore, Louisville; Airzzie W. Green, Jr., Lyndon; Michael Thomas, Disputanta. Second Row—(left to right)—Carroll Steinfield, Madisonville; William Bechmann, Jr., Covington; John Fielding, Jr., Lakeside Park; Glen D. Richards, Hawesville; Jack C. Lewis, Pineville; Mary A. Hall, Wheelwright. Top Row—(left to right)—Terrell Mays, Corbin; O. C. James, Neon; C. G. Noss, Berea; J. D. Fraim, Paintsville; R. B. Chambliss, Hardinsburg; Stanley R. Huffman, Lexington. Not pictured are: Joe E. Hills, Nashville, and James D. Shanklin, Mayslick.

Conference on Athletic Injuries Sponsored by KSMA

The KSMA will sponsor Kentucky's first conference on athletic injuries and their prevention at Memorial Coliseum, Lexington, on August 12. Cooperating with the KSMA in presenting the conference will be the Advisory School Health Council, the Kentucky High School Athletic Association, and the University of Kentucky Athletic Association.

All Kentucky physicians are invited to the half-day conference. Physicians are especially urged to call this meeting to the attention of athletic coaches in their community.

Prominent physicians and outstanding personnel in the field of sports will take part in the conference. Carroll L. Witten, M.D., Louisville, will preside. Following is the program.

1:00 Registration

1:45 Call to Order and Purpose of meeting, Carroll L. Witten, M.D., Louisville

1:55 Official Welcome, Ted Sanford, Commissioner, KHSAA

2:00 Symposium
Moderator, Carroll L. Witten, M.D.
"The Prevention and Recognition of Head and Brain Injuries," Paul J. Ross, M.D., Louisville
"The Prevention and Recognition of Musculoskeletal Injuries," Charles F. Wood, M.D., Louisville
"The Prevention and Recognition of Internal Injuries," John M. Moorhatch, M.D., Louisville

3:00 Discussion Period—Audience participation

3:45 Recess

4:00 Symposium, Bernie Shively, director of athletics, University of Kentucky
"Responsibility of the Coach," Joe Ohr, principal and coach, Irvine High School
"Responsibility of the Trainer," John "Rusty" Payne, Trainer, University of Kentucky
"Responsibility of the Physician," Owen B. Murphy, M.D., Lexington
"Responsibility of the Athlete," Frank Ramsey Boston Celtics, Madisonville

4:40 Discussion Period—Audience Participation

5:30 Adjournment

U of L Alumni Reunions Planned During Annual Meeting

Ten classes of the University of Louisville School of Medicine will hold their reunions and will attend the annual alumni dinner held in conjunction with the KSMA Annual Meeting at the Brown Hotel on Thursday night, September 24, according to Leslie Shively, director of the University's alumni.

Classes holding reunions this year will be the classes of 1909, 1914, 1919, 1924, 1929, 1934, 1939, 1944, 1949, and 1954. Chairmen for the various class reunions had not been named at press time, but will be listed in the August issue of the Journal.

This year marks the 50th reunion for the class of 1909 and the 25th for the class of 1934.

Medical Care Plans, Osteopathy, Social Security and General Practice Major Issues Discussed by AMA House of Delegates*

Four major problems dominated the activities of members of the AMA House of Delegates at its 108th annual meeting in Atlantic City, June 8-12. These issues were:

a. The report of the AMA's Commission on Medical Care Plans
b. Relations between medicine and osteopathy
c. Compulsory social security for physicians
d. Preparation for general practice

The largest number of alternate delegates, state presidents and medical society staff people ever to observe the House of Delegates in action were on hand for each of its three sessions. The large attendance indicated the high degree of importance and interest attached to the actions taken at the 1959 meeting.

Commission on Medical Care Plans

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item (see supplement to January 17 issue of the Journal of AMA, pages 92-93). The House adopted 36 of the recommendations without change, but reworded three which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

B-4. "In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

B-6. "Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers."

B-16. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

" 'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.' "

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and various types of third parties. To carry out three of the recommendations involving AMA activities, the House also approved a seven-point program which it requested the Board of Trustees to transmit to the Division of Socio-Economic Activities for immediate attention.

Medicine and Osteopathy

In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding inter-professional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an ostheopathic college which is in the process of being converted into an approved medical school under the supervision of the AMA Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the AMA to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level."

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission on Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

**See story on opposite page on Kentucky Delegation's organization for covering AMA House's reference committees.*

Social Security

In considering five resolutions on the subject of compulsory Social Security coverage for self-employed physicians, the House disapproved of four and adopted one reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the Association's entire legislative program, particularly with respect to the Forand Bill.

The House also recognized "the apparent growing demand by physicians for economic security" and requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to Association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security."

Preparation for General Practice

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new two-year internship program for medical school graduates planning to become family physicians. The Committee on Preparation for General Practice included representatives from the AMA Council on Medical Education and Hospitals, the American Academy of General Practice, and the Association of American Medical Colleges.

The suggested program would include a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spend the remaining six months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least four months of the elective period in obstetrical training.

The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in outpatient care and emergency room service.

House of Delegates Briefs

Other actions taken by the House of Delegates:

Urged all physicians to participate more fully in community activities and socio-economic matters in their respective communities;

Asked the AMA Board of Trustees to study problems and possibilities of establishing an AMA sponsored medical scholarship or loan program;

Voted to include "Today's Health" as one of the benefits members receive from paying dues and urged members to make it available to their patients;

Reaffirmed its full support of the Educational Council for Foreign Medical Graduates;

Urged all AMA members to give substantially to medical schools through the American Medical Education Foundation;

And, expressed appreciation for the outstanding disaster medicine program presented by the US Army Medical service on June 6.

Drs. Pierce and Long Represent KSMA in AMA House

KSMA was represented in the AMA House of Delegates at its June sessions in Atlantic City by Delegates W. Vinson Pierce, M.D., Covington, and Robert C. Long, M.D., Louisville. Doctor Pierce served on the Reference Committee on Sections and Section Work.

Also present were: George P. Archer, Prestonsburg, Alternate Delegate; Karl D. Winter, M.D., Louisville, who represented Alternate Delegate Foster Coleman, Louisville, who was unable to attend; and Irvin Abell, Jr., M.D., Louisville, KSMA president-elect.

After all reports were assigned to reference committees on Monday night, June 8, KSMA's delegation caucased and the Senior Delegate Doctor Pierce assigned someone to cover all major reference committee meetings. Covering the meetings besides the delegates and alternate delegates were: William R. Willard, M.D., Lexington; David Cox, M.D., Louisville; J. P. Sanford, and Bobbie Grogan, KSMA Headquarters Office; and Harry Lehman, Jefferson County Medical Society.

Another meeting of the delegation was held on Tuesday for a report on the hearings for the benefit of the delegates.

Seniors, Professors Honored at U of L Convocation

Seniors W. Neville Caudill and Hubert J. Wolfe won top awards—the outstanding senior and top scholar, respectively—at the University of Louisville Medical School honors convocation at General Hospital on May 26.

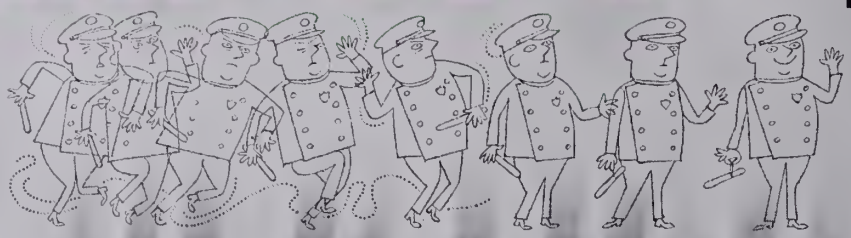
Chosen best teachers by a secret vote of students were Joseph A. Little, M.D., associate professor of pediatrics and physician-in-chief at Children's Hospital and K. C. Huang, M.D., assistant professor of pharmacology. Doctor Little was chosen best clinical professor and Doctor Huang best pre-clinical professor.

Caudill, president of the Student AMA, also won the Henry Enos Tuttle Award for the best essay on "The Ideals of Medicine."

Future AMA Meeting Dates Set

The next Clinical Meeting of the American Medical Association has been scheduled for December 1-4 in Dallas, Texas, according to the AMA's *Daily Bulletin*. Next Annual Meeting of the Association, at which E. Vincent Askey, M.D., Los Angeles, will be inaugurated as 114th AMA president, will be at Miami Beach, Florida, on June 13-17, 1960.

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Indications: Meniere's syndrome, arteriosclerotic vertigo, labyrinthitis, and streptomycin toxicity. Also effective in recurrent headache, including migraine.

Dosage: one tablet before each meal.

Supplied: bottles of 100 blue-and-white scored tablets. Prescription only.

References: 1. Charles, C. M.: Geriatrics 2:110 (March) 1956. 2. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956.

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Science for the world's well-being

Dr. Askey Named President-Elect of AMA for 1959-60



Dr. Orr



Dr. Askey

E. Vincent Askey, M.D., 63-year-old Los Angeles surgeon, was named President-Elect of the American Medical Association by the AMA's House of Delegates in Atlantic City on June 11. Doctor Askey, who was formerly vice speaker of the House, will succeed Louis M. Orr, M.D., Orlando, Florida, as president in 1960. Doctor Orr was inaugurated as president at this year's meeting to succeed Gunnar Gundersen, M.D., LaCrosse, Wis.

Elected vice president of the Association was J. Stanley Kenney, M.D., New York City. New speaker of the House, succeeding Doctor Askey who had been in that office since 1955, is Norman A. Welch, M.D., Boston. Doctor Welch had served as vice speaker for the last year. Named new vice speaker was Millard O. Rouse, M.D., Dallas, president of the Southern Medical Association.

Percy E. Hopkins, M.D., Chicago, was elected to the AMA Board of Trustees for the first time. Re-elected to five year terms on the Board were: R. B. Robins, M.D., Camden, Ark., and Hugh E. Hussey, Jr., M.D., Washington, D. C.

52 Ky. M.D.'s at AMA Meeting in Atlantic City in June

Largest physician registration at an Atlantic City AMA meeting since the AMA Centennial there in 1947 was recorded in the first four days of the convention in June. Physician registration was 12,921—including 11,806 AMA members, 809 residents, and 306 interns. Grand total, including physicians and guests, was 28,255.

Fifty-two Kentucky physicians traveled to Atlantic City for the Association's 108th Annual Meeting.

A list of Kentucky M.D.'s attending as recorded in the AMA's *Daily Bulletin,* follows:

Sunday

George P. Archer, Prestonsburg; Oren A. Beatty, Louisville; John B. Floyd, Jr., Lexington; Robert C. Long, Louisville; W. Vinson Pierce, Covington; Karl Winter, Louisville; William E. Yancey, Louisville.

Monday

George F. Archer, Jr., Louisville; David M. Cox, Louisville; M. R. Cronen, Louisville; K. L. Druet, Salina; J. Duffy Hancock, Louisville; George J. Hermann, Fort Thomas; Wilbur R. Houston, Erlanger; A. L. Hughett, Jr., Hazard; Allyn F. Judd, Whitesburg; Norman K. Kirby, Fort Knox; Ernest J. Landry, Madisonville; Agim Leka, Louisville; Edward H. Ray, Lexington; Saul Rubin, Lexington; Frances R. Sherman, Martin; John J. Sherman, Martin; George I. Uhde, Louisville; William R. Willard, Lexington; John H. Willard, Harlan; Carroll Witten, Louisville; W. K. Wood, Middlesboro; Nathan Zimmerman, Valley Station.

Tuesday

Irvin Abell, Jr., Louisville; Lundy Adams, Whitesburg; Asa Barnes, Louisville; Joseph C. Bell, Louisville; Warren H. Diessner, Middlesboro; George E. Dodson, Madisonville; Clyde H. Foshee, Louisville; Jesse E. Funk, Bowling Green; J. T. Gilbert, Bowling Green; R. F. Greathouse, Louisville; Arthur T. Hurst, Louisville; Jerome L. Jacobs, Fort Knox; Alfred E. Jaunzems, London; Irving F. Kanner, Lexington; J. Murray Kinsman, Louisville; A. C. Kennedy, Valley Station; Willett H. Rush, Frankfort; Joseph Schickel, Burnesville; Frank K. Sewell, Mt. Sterling.

Wednesday

Robert Lich, Jr., Louisville; Hugh B. Lynn, Louisville.

Thursday

Franklin Jelsma, Louisville; Edward C. Shrader, Louisville.

Ky. Medical Executives Meet in Atlantic City

A wide scope of subjects were covered at the Annual Meeting of the Medical Executives Association in Atlantic City on June 5, 6, and 7 during the AMA Annual Meeting. Representing Kentucky at the sessions were J. P. Sanford asd Bobbie R. Grogan of the KSMA Headquarters Office and Harry Lehman of the Jefferson County Medical Society.

Luncheon speaker on the opening day of the meeting was Harold Stassen, former Governor of Minnesota and President of the University of Pennsylvania. Subjects under discussion at the meeting included: "The Communications Job of the Medical Society," "Permanent Liaison Among the Professions," "New and Significant Services a Medical Society May Offer Its Membership," and "Changing Aspects of Blue Shield-Blue Cross Operations."

Sanford was chairman of the nominating committee for 1959-60 officers of the Association.

New KSMA Members Listed

Recently added to the KSMA membership roster were:

H. A. Perry, M.D., Stearns

John N. Goldsborough, M.D., Louisville

NOW—*YOU CAN PRESCRIBE THE UNSURPASSED ADVANTAGES O*

superior antiallergic efficacy with new low dosage

NEW

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- combines the **anti-inflammatory, antiallergic** and **antihistaminic** effects of two agents—ARISTOCORT and chlorpheniramine which, separately, have been proved highly effective in the treatment of allergy
- permits **greater latitude** in adjusting dosage to minimum level needed for maintenance, because ARISTOCORT and chlorpheniramine are supplied in the **lowest dose tablets available** for each component alone
- supplies **ascorbic acid** for increased demand in stress conditions

Indications: *Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.*

Dosage: *One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.*

Precautions: *Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with* ARISTOMIN *have been relatively infrequent and minor in nature. However, since* ARISTOCORT *Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to corticosteroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.*

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Supply: *Each* ARISTOMIN *Capsule contains:*

ARISTOCORT® *Triamcinolone..... 1 mg.*
Chlorpheniramine Maleate..... 2 mg.
Ascorbic Acid.....75 mg.

Bottles of 30 and 100

References: *1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.*

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"I would conclude that ARISTOMIN *is truly a worthwhile aid in treating allergic problems."*[1]

"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."[2]

"In general . . . it [ARISTOMIN] *is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."*[3]

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Dr. Massie Reports on Progress at McDowell House

In conjunction with the dedication of the Apothecary Shop, which adjoins the McDowell House in Danville, on August 15, Francis M. Massie, M.D., Lexington, co-chairman of the McDowell House Committee, has issued the following progress report to the Journal.

"In 1936, the Kentucky State Medical Association raised a little more than $16,000 and bought the home of the late Ephraim McDowell, M.D., in Danville. In December 1809, in this house Dr. McDowell performed the first successful removal of an ovarian cyst in the world's history. The patient lived a healthy and useful life for 32 more years and died in her seventy-ninth year.

"Led by Irvin Abell, Sr., M.D., Arthur T. McCormack, M.D., and Charles A. Vance, M.D., the State Medical Association persuaded Mr. Harry Hopkins in 1937, to undertake, as a W. P. A. project, the restoration of the McDowell House. The W. P. A. after careful study did a complete and artistically satisfactory job. About 30,000 dollars was spent to restore the house and garden.

"The Women's Auxiliaries of the State Medical Society and of three county medical societies undertook to furnish the home properly and with historical accuracy. The resulting effect is beautiful.

"Since 1950, the McDowell House has been supported by appropriations each year from the KSMA which owns the property, the Kentucky Surgical Society, the private gifts and income from the admission fees. This totals some $3,100 annually,

"In 1958, the Southern Surgical Association gave $200 to help in the maintenance; it is hoped that this gift will be an annual one.

"Since 1936, nearly $100,000 have been spent for the restoration, and the results have justified the expense.

"The pharmacists of Kentucky in 1955, became interested in Doctor McDowell's apothecary shop, a small one-story brick building in contact with the home, facing the same way. No funds had been available for work on this building until the Kentucky Pharmaceutical Association raised $10,000 to purchase and remove a ram-shackle two-story brick building immediately adjacent to the apothecary shop. The property was presented to the Kentucky State Medical Society by the pharmacists under the leadership of Dr. Earl Slone, Dean of the Kentucky College of Pharmacy and Mr. E. M. Josey, Secretary of the State Pharmaceutical Society.

"The Eli Lilly Company of Indianapolis was informed of the possible restoration of the 'first apothecary shop west of the Alleghenies.' They studied the project and gave $20,000 through the thoughtful generosity of the President of the Foundation. This will be enough to restore the shop in harmony with the restoration of the home."

Woman's Auxiliary Plans Tour During Annual Meeting

The KSMA Woman's Auxiliary is planning a tour for its members during the Association's Annual Meeting on Thursday, September 24. Tour chairman is Mrs. Murray Kinsman, Louisville.

Although tour plans were in tentative stages as the Journal went to press, Mrs. Kinsman stated that it was hoped that a visit to Farmington could be included, as well as a tour and luncheon at the General Electric plant.

Full details on tour plans will appear in the August Annual Meeting issue of the Journal.

Pres. Eisenhower Addresses AMA at Inaugural Dinner, June 9

An overflow crowd of 5000 heard President Dwight D. Eisenhower speak at the inaugural dinner during the American Medical Association's Annual Meeting in Atlantic Ctiy on June 9.

Thousands of others were turned away from the inaugural dinner, where the President spoke on "The Doctor's Influence on Civilization." Mr. Eisenhower's talk followed the inaugural address of Louis M. Orr, M.D., Orlando, Fla., the AMA's 113th President.

President Eisenhower's talk and other activity at the meeting were covered for the nation's newspapers by 300 newsmen, representing papers from coast to coast. Included in the news group were 20 members of the Washington press corps who were flown to Washington to cover the President's address.

KAGP Plans PG Seminars

The Kentucky Academy of General Practice is planning two postgraduate medical seminars in July and August, according to an announcement from Daryl P. Harvey, M. D., Glasgow, KAGP president.

On July 30 the Henderson Seminar will be held in Henderson. Robert L. Sumner, M.D., Henderson, is chairman of this postgraduate program. August 16 is the date of the Lexington Seminar of which Robert M. Circle, M.D., Lexington, is chairman. Details on the seminars were not available at press time.

AMEF Contributions Total $178,330

Contributions to the American Medical Education Foundation totalling $178,330 from representatives of the Illinois State Medical Society, the Alaska State Medical Society, and the East Mississippi Medical Association were accepted by George F. Lull, M.D., president of the AMEF at brief ceremonies during the AMA House of Delegates meeting. Illinois's gift, representing contribution from all its members was $176,330; Alaska and East Mississippi each presented a contribution of $1,000. These gifts brought the 1959 total to $325,310.

Names of Scientific Consultants Announced by Editors

Editor of the Journal of the KSMA Sam A. Overstreet, M.D., Louisville, has anounced the names of eight new members of the Board of Consultants on Scientific Articles of the Journal of the KSMA.

Terms of the members of the Board were effective July 1. Appointments were made by Doctor Overstreet and Associate Editor George W. Pedigo, Jr., M.D., Louisville.

Appointed to the Board to serve until July 1, 1962 were: Sam S. Clark, M.D., Louisville; Gene N. Combs, M.D., Pikeville; James T. Gilbert, Jr., M.D., Bowling Green; Albert E. Leggett, Jr., M.D., Louisville; Owen Murphy, M.D., Lexington; William E. Oldham, M.D., Louisville; Malcom D. Thompson, M.D., Louisville; and A. J. Whitehouse, M.D., Lexington.

Retiring after serving since 1956 are: Robert E. Buten, M.D., Fort Thomas; Thomas J. Crume, Jr., M.D., Owensboro; German P. Dillon, M.D., Louisville; Pat R. Imes, M.D., Louisville; Stanley S. Parks, M.D., Lexington; William C. Roland, M.D., Ashland; Maurice Walsh, M.D., Covington; and Harold D. Priddle, M.D., Paducah.

Doctors Overstreet and Pedigo expressed the Journal staff's appreciation for the work of the retiring consultants during the past three years.

Med. Freshmen Pledge to U of L Fund

All 98 members of the U of L Medical School freshman class have now made pledges of more than $1000 each to the U of L development program. Barney E. Elliott, Jr., class president, said the pledges to be paid by the 10th year of practice after graduation, total $98,100.

Announcement of class pledges totalling $86,150 by 81 members of the class was made at a meeting of the program's special gifts committee recently. The over-all fund drive seeks $2,489,585 this year and $25,000,000 over a 10-year period. This year's contributions will go for a new medical-dental research building and cancer treatment center, physical education building, and books and equipment. The development program had already hit the $1,000,000 mark as the Journal went to press.

Drs. DeBakey and Bayne-Jones Honored at AMA Meeting

Michael E. DeBakey, M.D., Houston, Tex., chairman of the department of surgery, Baylor University College of Medicine, was selected by the AMA House of Delegates to receive the Association's Distinguished Service Award. Doctor DeBakey was cited for his many contributions in the advance of heart and blood surgery, including development of the milking-action pump which has been widely used in heart-lung machines.

Winner of the 1959 Passano Foundation Award was Stanhope Bayne-Jones, M.D., who was honored for his contributions to medicine and particularly to medical education. One of Doctor Passano's outstanding achievements was the publishing in 1958 of a report on "The Advancement of Medical Research and Education."

KSMA Golf Tournament Slated for Big Spring Golf Club

The annual Kentucky State Medical Golf Association tournament will be held at the Big Spring Golf Club on September 22, 23, and 24.

Lanier Lukins, M.D., Louisville, chairman of the KSMA Golf Committee, reports that his committee has voted to increase the golf dues to $6. The increase will take care of the green fee, in addition to the membership fee, which results in an actual lower cost this year for each golfer.

Prizes, plus one year's possession of traveling trophies, will be presented to those winning top honors in the low gross, low net, and senior championship categories. In addition, daily prizes will be awarded.

Plans are underway for members of the KSMA Golf Committee to be present at the Big Spring Golf Club during the tournament for the purpose of serving as hosts and to give the players any assistance.

Any golfer desiring to play should mail the $6.00 dues to the Kentucky State Medical Golf Association, at the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17. For your convenience, the application blank may be detached and mailed to the Headquarters Office along with the $6.00 dues.

Members of the golf committee, in addition to Doctor Lukins, are: Harold Baker, M.D., Louisville; Clifton G. Follis, M.D., Glasgow; Merle W. Fowler, Jr., M.D., Paducah; Martin Kaplan, M.D., Louisville; Kenton D. Leatherman, M.D., Louisville; William C. Wolfe, M.D., Louisville; and Robert M. Wooldridge, M.D., Paducah.

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KSMA Golf Association

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Cash enclosed is $6.00..... Check, $6.00.....

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(circle day or dates)


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it could be mild
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chronic, primary or
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more potent and comprehensive treatment than salicylate alone

. . assured anti-inflammatory effect of low-dosage corticosteroid[1] . . . additive antirheumatic action of corticosteroid plus salicylate[2-5] brings rapid pain relief; aids restoration of function . . . wide range of application including the entire fibrositis syndrome as well as early or mild rheumatoid arthritis

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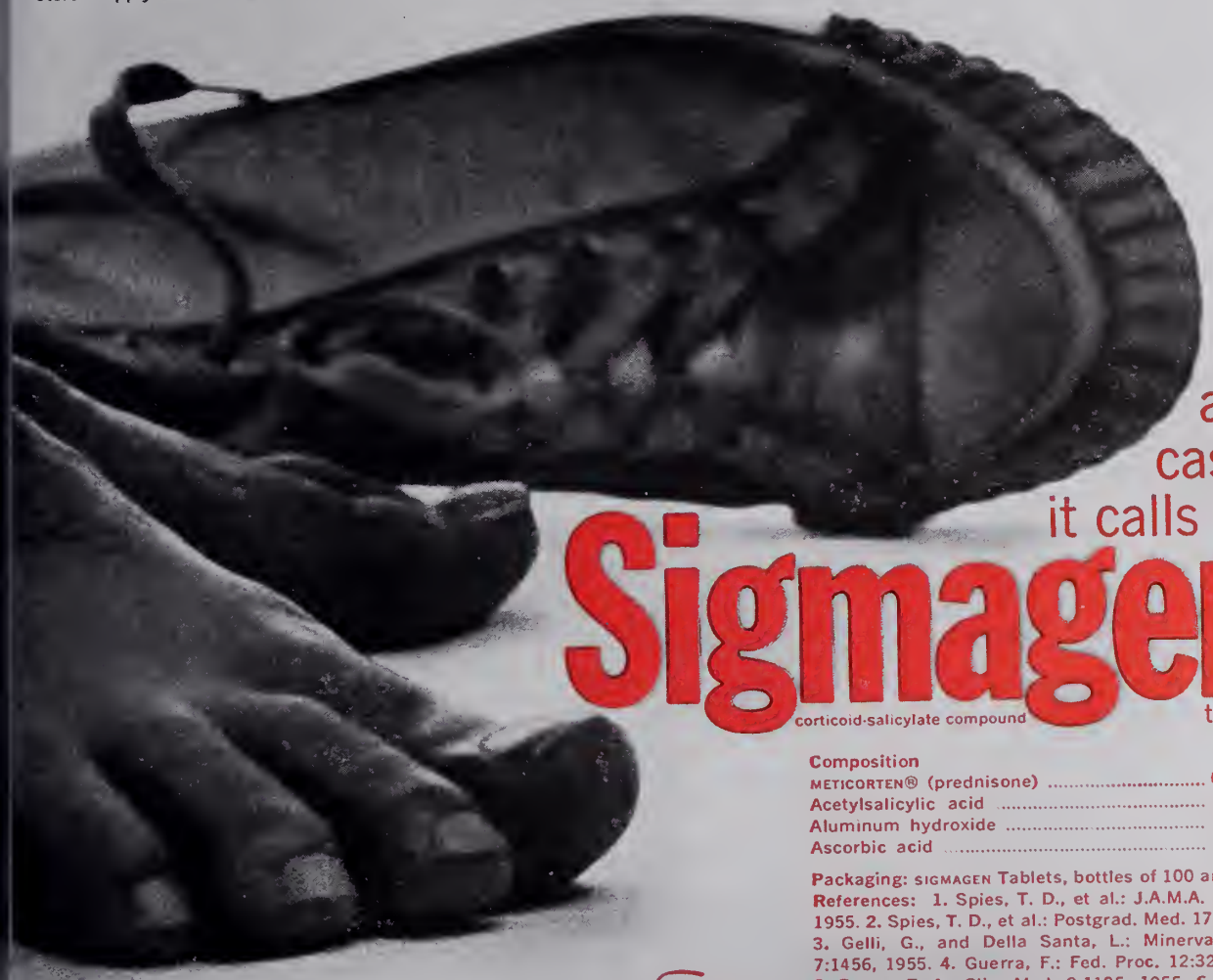
. much less likelihood of treatment-interrupting side effects[1-6] . . . reduces possibility of residual injury . . . simple, flexible dosage schedule

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acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



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corticoid-salicylate compound

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METICORTEN® (prednisone)	0.75 mg.
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Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Schering

SG-J-618



Officers of the Kentucky Society of Internal Medicine posed following their annual meeting in Lexington. From left to right are—Carl Fortune, M.D., Lexington, president-elect; George W. Pedigo, M.D., Louisville, president; and Franklin B. Moosnick, M.D., Lexington, outgoing president.

Internists Meet in Lexington

Carl Fortune, M.D., Lexington, was chosen president-elect of the Kentucky Society of Internal Medicine at the Society's annual meeting in Lexington on June 5. Installed as president for 1959-60 was George W. Pedigo, Jr., M.D., Louisville.

Ralph Denham, M.D., Louisville, was elected secretary-treasurer. Outgoing president was Franklin B. Moosnick, M.D., Lexington. Among other business discussed at the meeting was a report on the national meeting of the group held in conjunction with the meeting of the American College of Physicians.

Fund Honors Dr. L. C. Hafer

L. C. Hafer, M.D., retired northern Kentucky physician and past vice president of the KSMA, has been honored by a fund which has been established for the Kenton-Boone Opportunity School in Kenton. A pioneer leader in work for crippled children, Doctor Hafer has long been active in KSMA affairs and is a past president of the Campbell-Kenton Medical Society. A number of groups and individuals have established the fund, which began with a donation from an anonymous donor.

Joint 4th & 6th Meeting Attracts 80

Approximately 80 physicians and their wives attended the joint meeting of the Fourth and Sixth Councilor Districts at Mammoth Cave Hotel on Thursday, June 18.

District Councilors W. Keith Crume, M.D., Bardstown, and John P. Glenn, M.D., Russellville, expressed appreciation for the fine program and good attendance. KSMA president Robert W. Robertson, M.D., Paducah, was a featured speaker. On the scientific portion of the program were: Glenn W. Bryant, M.D., Louisville; Leslie C. Dodson, M.D., Owensboro; and Robert S. Tillett, M.D., Louisville.

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Children's Hospital Seeks Funds

In order to continue to provide its services to the community, Children's Hospital in Louisville is now conducting a financial campaign of its own. Formerly it received its support from the Community Chest. As the Journal went to press, the campaign was in its organizational stages. General solicitation will take place from mid-July through the early part of August. The Children's Hospital Sustaining Fund Campaign Headquarters is the Arcade Building, 320 West Chestnut St., Louisville, Ky. E. P. Welteck is director.

Southeastern Surgeons Offer Prize

The Southeastern Surgical Congress is awarding $100 and expenses to attend its annual meeting in New Orleans on March 21-24, 1960 for the best unpublished contribution on surgery or allied subjects as its scientific paper award for 1959. The contest is open to residents in AMA approved residences in Kentucky and 13 other southern states. Three copies of the paper should be sent to the Congress's Councilor from Kentucky before the December 1, 1959 deadline. Kentucky's Councilor is: J. Duffy Hancock, M.D., 704 Brown Building, Louisville 2, Ky.

Epidemiology Society Elects

The president of the newly organized Kentucky Epidemiological Society is Maurice Kamp, M.D., head of the Louisville and Jefferson County Board of Health. Membership in the group is limited to 50 and is open to those engaged in public health work, instruction or research. Other officers, all from the State Department of Health are: vice president, Ruth Spurrier, director of the division of public-health nursing; secretary, Joe F. Sills, director of the division of training and recruitment, and Nick G. Johnson, assistant director of the division of engineering.

Mass Polio Vaccination Urged

Urging communities to conduct block-by-block polio vaccination campaigns Surgeon General Leroy E. Burney of the U. S. Health Department said, "If communities continue to delay in pushing major drives to reach the unvaccinated, most of whom are located in the lower socio-economic groups, tragic outbreaks may be expected."

Paralytic-polio cases throughout the nation total 265—about double what they were between April 1 and June 13 a year ago. Commenting on the Kentucky situation, Russell Teague, State Commissioner of Health said, "There have been 11 polio cases in Kentucky up to June 27. Nine of these have been paralytic and two non-paralytic. About 65 per cent under 40 in the state in the upper economic levels are immunized. Only about 30 per cent are immunized in the lower economic level. The State Department has allocated an additional $10,000 for the purchase of vaccine to be distributed to the counties for indigents only."

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In Memoriam

W. J. SHACKLETTE, M.D.
Hodgenville
1871 - 1959

Warner J. Shacklette, M.D., Hodgenville, died at the Glasgow hospital on June 8 after a short illness. Doctor Shacklette, who had practiced medicine for 61 years, was one of seven south central Kentuckians honored at an appreciation dinner in Hodgenville in April.

Doctor Shacklette practiced in Nolin and Glendale before moving to Hodgenville in 1924. A native of Meade County, he attended the old Hospital College of Medicine, now the University of Louisville School of Medicine.

SAMUEL M. RICKMAN, M.D.
Paris
1903 - 1959

Samuel M. Rickman, physician and surgeon, died on May 21 of a heart attack suffered while working in his garden. He had practiced in Bourbon County since 1934, except for a period during World War II when he served in the armed forces.

A native of Stuart, Virginia, Doctor Rickman was a graduate of Emory University School of Medicine in 1930. He took his residency training at Norton Memorial Infirmary in Louisville.

VA Honors Dr. Erwin Straus

Erwin W. Straus, M.D., director of the research and education service of the Lexington VA Hospital and internationally known psychiatrist, recently received the highest award given by the Veterans Administration's Department of Medicine and Surgery—the Chief Medical Director's Commendation. The award was given during the VA's annual research conference on chemotherapy in psychiatry at the Memphis Kennedy VA Hospital in recognition of Doctor Straus's outstanding contribution to the VA medical program.

Committee Reports

KSMA Associate Committee on Nurses Training

Henry B. Asman, M.D., Louisville, Chairman

Louisville **May 21**

One of the main topics discussed was a study of shortage of nurses and the preparation of a statement on this subject. The statement will be presented to the KSMA Council for its consideration at its next meeting.

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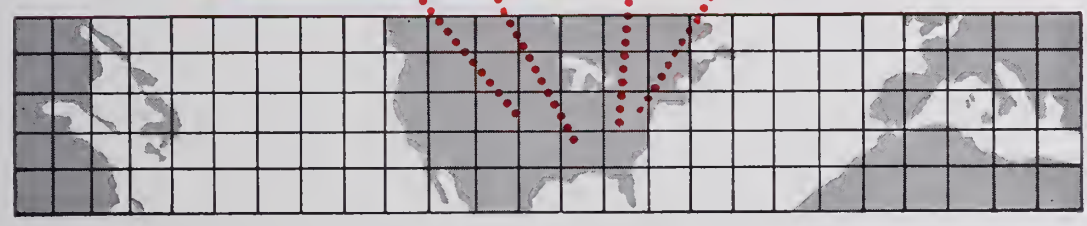
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ATARAX is "effective in controlling tension and anxiety.... Its safety makes it an excellent drug for out-patient use in office practice."[4]



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For adult tension and anxiety	25 mg. tablets Syrup	one tablet q.i.d. one tbsp. q.i.d.
For severe emotional disturbances	100 mg. tablets	one tablet t.i.d.
For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

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References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6.Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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NEWS ITEMS

J. C. McGuire, M.D., resigned as health officer for the Lexington-Fayette County Health Department, effective June 26. Doctor McGuire, who was appointed health officer in October of 1958, has accepted a post as tuberculosis control officer in Houston, Texas.

James T. Gilboy, M.D., resigned recently as superintendent of the Julius Marks Sanatorium in Lexington. He has accepted a post as staff physician in the tuberculosis section of the U. S. Veterans Hospital at Excelsior Springs, Mo.

J. C. Rogers, M.D., Henderson, has retired from active practice and is now health officer of Henderson County. Doctor Rogers, a graduate of the University of Chicago, Rush Medical School started practice in Henderson in the 1930's and had practiced there for 27 years before his retirement.

William R. Willard, M.D., Lexington, dean of the University of Kentucky Medical School, received an honorary doctor-of-science degree from Transylvania College at its commencement exercises on June 15. The award commemorates the 100th anniversary of the closing of Transylvania's famous early medical school. Doctor Willard was principle speaker at the commencement.

Alvin Lebendiger, M.D., has recently started practicing general surgery in Louisville. He is a 1950 graduate of the Columbia College of Physicians and Surgeons. Doctor Lebendiger took his internship at Philadelphia General Hospital, his residency at VA hospital, Brooklyn, N. Y., Mt. Sinai Hospital, New York, and Montefiore Hospital, Bronx, N. Y. He served as a lieutenant in the USPHS and the U. S. Coast Guard with the rank of lieutenant. He is a native of New York City.

W. P. McKee, M.D., has started the practice of general surgery in Shelbyville at the Klein-McKee Clinic. A graduate of the University of Louisville School of Medicine in 1939, Doctor McKee took his internship and residency training at Kentucky Baptist Hospital. He served 3½ years with the 101st Airborne Division as a parachutist in the medical corps with the rank of Lieutenant Colonel. Since the War, he has practiced at the Henry County Clinic in Eminence.

Ten major national health agencies raised a total of $161,843,030 during the past fiscal year, the American Association of Fund Raising, Counsel, Inc., New York reported recently. All of the reporting agencies are well known to the public for their annual national appeals. Each agency reported individual expenditures in five major areas and the results showed that the highest percentage of spendings for the combined agencies was for medical treatment—39.5 per cent.

Irvin Abell, Jr., M.D., Louisville, KSMA president-elect, was recently appointed a member of the Board of Overseers of Bellarmine College in Louisville. His appointment to the Board was effective July 1. **J. Duffy Hancock, M.D.,** Louisville, is chairman of the Board.

Raymond Robert Knowles, M.D., succeeded **Leslie Wright, M.D.,** as superintendent of Kentucky State Hospital in Danville on June 1, according to an announcement from H. L. McPheeters, mental health commissioner. Doctor Wright, who resigned to "lessen his responsibilities" left Kentucky for a position in Missouri. A native of Sydney, Australia, Dr. Knowles graduated from the Medical School of Sydney University in 1947. After two years of practice in New South Wales, he went to England until May, 1955 when he came to Kentucky State Hospital. He was promoted to Clinical director of the hospital in 1956.

M. A. Shepherd, M.D., a native of Science Hill and a graduate of the University of Louisville School of Medicine in 1953, has been named director of the Pulaski, Laurel, and McCreary County Health Departments. He suceeds **Jo Ann Sexton, M.D.,** who left in January to study pediatrics at Children's Hospital, Louisville. Doctor Shepherd interned at Kentucky Baptist Hospital, Louisville and then practiced medicine and surgery in Harrodsburg for two years. In 1956, he became health officer in Henderson, Webster, and Union Counties. After two years there, he enrolled in the School of Public Health at the University of North Carolina receiving his Master of Public Health degree on June 1.

Leslie Van Nostrand, M.D., has been appointed medical director of General Electric's Appliance Park in Louisville. He succeeds the late Alden E. Terry, M.D. Doctor Van Nostrand is a graduate of Long Island College of Medicine in 1947 and interned at Brooklyn Hospital and took his residency training at Huntington Hospital. From 1949-50 he was in private practice in Huntington, N. Y. In 1952 upon his return from the service he joined GE serving four years as a laboratory physician at Knolls Atomic Power Laboratory in reactor and radiation development research work.

William Charles Gardner, M.D., has started the practice of thoracic surgery at the Trover Clinic in Madisonville. A graduate of the College of Medical Evangelists in 1943, he interned at Los Angeles County General Hospital and took his residency training at Pontiac General Hospital, Pontiac, Mich.; Jennings Memorial Hospital, Detroit, and University Hospital, Ann Arbor, Mich. He was a major in the Army Medical Corps. Before coming to Madisonville, he was chief of thoracic surgery service, Vancouver, Washington VA Hospital; and of the Portland, Oregon, VA Hospital.

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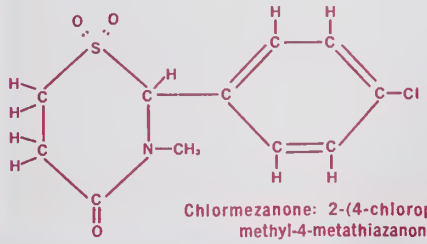
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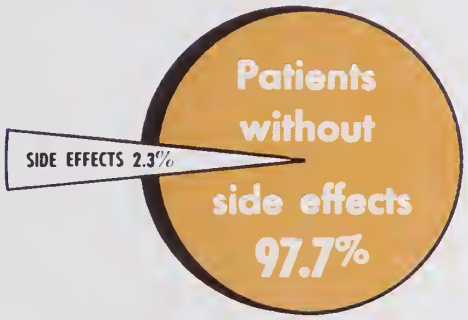
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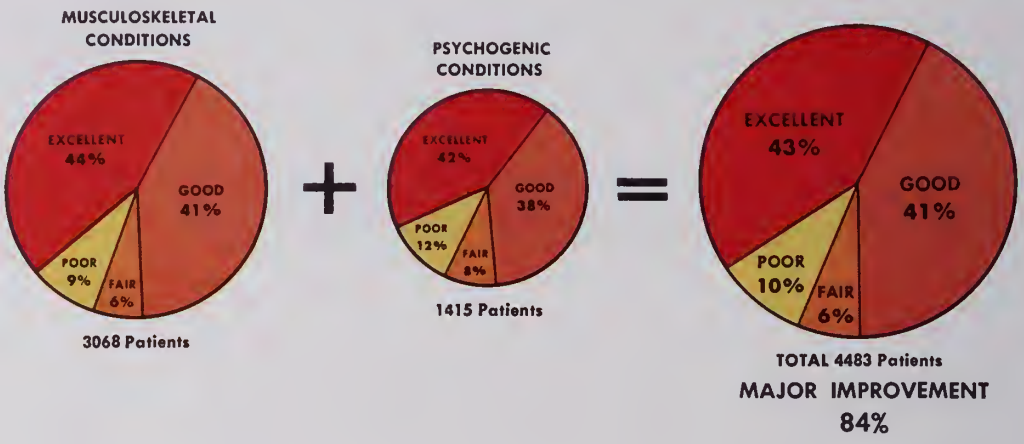
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References: 1. Collective Study, Department of Medical Research, Winthrop Laboratories. • 2. Ganz, S.E: J. Indiana M. A. In press. • 3. Lichtman, A.L.: Kentucky Acad. Gen. Pract. J. 4:28, Oct., 1958.

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[1]Sadove, Max S. and Schwartz, Lester: An Evaluation of Buffered Versus Nonbuffered Acetylsalicylic Acid, Postgraduate Medicine; 24:183, August, 1958.

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PERTINENT PARAGRAPHS

About 90 of Kentucky's 120 counties are now participating in some phase of brucellosis control, according to Agriculture Commissioner Ben Butler. He said Hopkins, Metcalfe, and Todd counties became brucellosis-free during March and April, bringing to 15 the counties in this category.

The American Institute of Ultrasonics in Medicine will hold its annual meeting on September 2 at the Leamington Hotel, Minneapolis, Minn. Guest speaker at the luncheon meeting will be Russell Myers, M.D., professor of surgery and chairman, division of neurosurgery, State University of Iowa Hospitals and College of Medicine who will discuss "The Potentials of Ultrasonics in General Surgery and Surgical Specialties." For further information contact: John H. Aldes, M.D., secretary, 4833 Fountain Ave., Los Angeles 29, Calif.

The 24th annual congress of the North American Federation, International College of Surgeons, will be held at the Palmer House in Chicago, September 13-17. Surgical specialties to be presented are: coloproctologic, neurologic, obstetric and gynecologic, ophthalmologic, otorhinolaryngologic, orthopedic, plastic and reconstruction, trauma and rehabilitation, and urologic. There will also be surgical motion pictures, reports on advances in military medicine, and a surgical nurses' program. Surgeons desiring to present papers should write to: Peter A. Rosi, M.D., International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

The American Rhinologic Society will hold its fifth annual meeting in the Belmont Hotel, Chicago, on October 10. The meeting will be preceded by a surgical seminar in the Illinois Masonic Hospital, Chicago, on October 7-9. The hospital clinical program will open on Wednesday evening with a special showing of scientific exhibits. On Thursday and Friday, the program will consist of lectures, surgical demonstrations, clinical reports with case presentations, and panels on osteotomies, implants and surgery of the lobular cartilages. The Society will hold its business meeting on Friday night. For further information write to: Robert M. Hansen, 1735 N. Wheeler Ave., Portland 12, Ore.

The Mid-Atlantic meeting of the International College of Surgeons will be held at the Homestead Hotel, Hot Springs, Va., on November 16, 17, and 18. All physicians are cordially invited to attend.

The American Goiter Association is again offering the Van Meter Prize Award of $300 to the essayist submitting the best manuscript of original and unpublished work concerning goiter—especially its basic cause. Studies may relate to any aspect of the thyroid gland and its functions in health and disease. Award will be made at the Fourth International Goiter Conference in London, England, July 5-9, 1960. For full details write: John C. McClintock, M.D., 149½ Washington Ave., Albany 10, New York.



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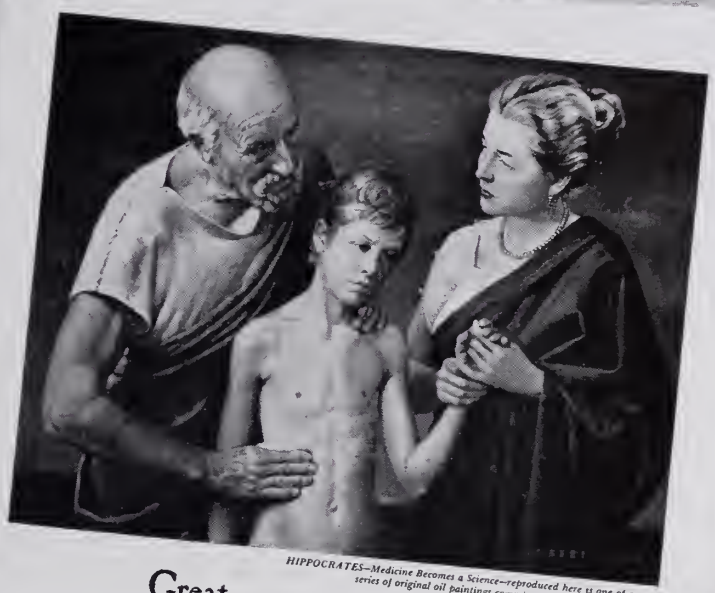
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The Commonwealth Fund is providing continuing support for the NLN Fellowship program. During the five years of its existence, 126 fellowships have been granted, 95 for fellows engaged in doctoral study and 31 for those studying at the master's level. The program provides generous fellowships for nurses having superior ability and leadership qualities who are engaged in programs of advanced study. Nurses with these qualities are urged to contact Rozella Schlotfeldt, chairman, Fellowship Program National League for Nursing, Inc., 10 Columbus Circle, New York 19, N. Y.

The Sister Elizabeth Kenny Foundation announces continuation of its program of post-doctoral scholarships to promote work in the field of neuromuscular diseases. These scholarships are designed for scientists at or near the end of their fellowship training in either basic or clinical fields concerned with the broad problem of the neuromuscular diseases. Kenny Foundation Scholars will be appointed annually. Each grant will provide a stipend for a five-year period at the rate of $5000 to $7000 a year, depending upon the scholar's qualifications. Candidates from medical schools in the U. S. and Canada are eligible. Inquiries regarding details of the program should be addressed to: E. J. Huenekens, M.D., Medical Director, Sister Elizabeth Kenny Foundation, Inc., 2400 Foshay Tower, Minneapolis 2, Minn.

The American Urological Association is offering an annual award of $1000 (first prize of $500, second prize, $300, and third prize, $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than 10 years, and to hospital internes and residents doing research work in urology. First prize essay will appear on the program of the meeting of the American Urological Association, Palmer House, Chicago, on May 16-19, 1960. For more details write: William P. Didusch, executive secretary, 1120 North Charles St., Baltimore, Md.

The Institute of Industrial Health of the University of Cincinnati announces that the fourth biennial course of instruction in "Occupational Skin Problems" will be given during the week of October 26-30. It will be presented by the Department of Preventive Medicine and Industrial Health of the University in collaboration with the Occupational Health Program of the U. S. Public Health Service and the Department of Dermatology of the University of Cincinnati. Objective of the course is to give physicians a greater understanding of cutaneous problems of occupational origin.

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The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Biltmore Hotel in Los Angeles, Calif., on September 24, 25, and 26. The course will cover advances in the diagnosis and treatment of gastrointestinal diseases. For further information write: American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

The Arthritis and Rheumatism Foundation offers pre and postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1960. Deadline for applications is October 31, 1959. The awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. For information and application forms write: Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

The Advance-Yeoman of Wickliffe, Ky., recently com- mented on the fact that, "It is cheaper to educate your son to be a doctor than to be a farmer." The comment was made in a column entitled, "Looking Ahead" written by Pat Magee. He states the approximate total spent to educate and set your son up in medical practice would be about $15,000; while the cost to educate your son at an agricultural college and to set him up on a farm would cost about $73,000 —even without providing the first head of livestock on the farm.

*1. Borrus, J. C.: J.A.M.A. 157:15[illegible]ril 30, 1[illegible] 2. Sell[illegible] S.: J.A.M.A. 157:1594, April 30, 1955. 3. Lemere, F.: [illegible]thwest Med[illegible]098, Oct. [illegible]5. 4. Bene[illegible] B. and M[illegible]ocutti, C.: Lav. neuropsichiat. 18:693, 1[illegible] 5. Selli[illegible]S.: J. Clin[illegible] Exper. Psy[illegible]th. 17:7, [illegible]arch 1956. 6. Berglund, M., Blumenthal, B.[illegible]lordh, P.:[illegible]nska läk. 53:3362, Dec. [illegible]1956. 7.[illegible]el, H. A., Wood, J. A. and Dixon, H. H.:[illegible]w York Aca[illegible]c. 67:780, May 9, 1957. [illegible]Hollister,[illegible]E., Elkins, H., Hiler, E. G. and St. Pierr[illegible]Ann. New Yo[illegible]k Acad. Sc. 67:789, May 9, [illegible]57. 9. Ga[illegible]T.: Rass. med. 34:233, July-Au[illegible]957. 10[illegible]i, R. et al[illegible]J. Pediat. Praxis 20:27, [illegible]g. 1957.[illegible]iklund, P[illegible]: Anaesthesist[illegible]07, Aug[illegible]7. 12. Tucker, W. I.: Sout[illegible]M. J. 50:1111, Sept. 195[illegible]5. Rolandi[illegible]: Attual. ostet.[illegible]3(6,[illegible]9, Nov.-Dec. 1957. 14.[illegible]hecker, W.: Klin. Mona[illegible]l. Augenh[illegible]2):224, 1958.[illegible]nebianco[illegible]G. and Ceroni, T.: Oto-[illegible]ring. ital. 26(2):143, 1958. 16.[illegible]o, G.: Minery[illegible]49:1914, 1958. 17.[illegible]tuso, R. and[illegible]tti, F.: Ac[illegible]eurol. 13(1):36, J[illegible]1958. 18.[illegible]Gazz. med. ital.[illegible]49, Feb. 195[illegible]Dastur, R.[illegible]: J. Indian M. Prof[illegible]13, Feb. 1958.[illegible]st, W.: Therap. G[illegible]t 97:66, Fe[illegible]21. Be[illegible]P.: Lyon méd. 19[illegible]March 2, 1958.[illegible]niglia, G.: Miner[illegible]10.218, M[illegible]15, 1958.[illegible]dlander, H. S.:[illegible]Cardiol. 1:395,[illegible]1958. 24. McCler[illegible]: Arch. Pe[illegible]75:101, M[illegible]25. Sprauer, V. J.[illegible]Internat. Rec. Med[illegible]GP Clinics 171:1[illegible]1958. 26.[illegible]inson, R.[illegible]Robinson, H M.,[illegible]r.: South. M. J. 51[illegible]9, April 1958. 27.[illegible], S. and Pe[illegible]er, L.: Ne[illegible]ed. 58:1285, April 15, 1958. 28. Bouquerel, J., Naviau and[illegible]ne: Ann. méd.[illegible]ychol. 116[illegible]ne 1958. 29. Reboul, E., Reboul, M. and Dorgeuille, C.: Maroc[illegible]37:784, July 1958. 30. B[illegible]Lyon méd. 200:885, Nov. 1958. 31. Lamphier, T. A.: Maryland M[illegible]7:627, Nov. 1958. 32. Leuke[illegible]Med. Klin. 53:2113, Dec. 1958.



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The Capitol House Hotel

BEAUMONT, TEXAS—Saturday, September 19, 1959
The Hotel Beaumont

KANSAS CITY, KANSAS—Friday, September 25, 1959
Battenfeld Memorial Auditorium

INDIANAPOLIS, INDIANA—Wednesday, Sept. 30, 1959
The Sheraton-Lincoln Hotel

OKLAHOMA CITY, OKLAHOMA—Friday, October 2, 1959
The Skirvin Hotel

BIRMINGHAM, ALABAMA—Sunday, October 11, 1959
The Dinkler-Tutwiler Hotel

TACOMA, WASHINGTON—Wednesday, October 14, 1959
The Hotel Winthrop

TRAVERSE CITY, MICHIGAN—Friday, October 23, 1959
The Park Place Hotel

LUBBOCK, TEXAS—Saturday, October 31, 1959
The Lubbock Country Club

ST. CHARLES, ILLINOIS—Wednesday, November 4, 1959
The St. Charles Country Club

DALLAS, TEXAS—Friday, November 6, 1959
The Hilton Hotel

WICHITA, KANSAS—Saturday, November 7, 1959
The Hotel Broadview

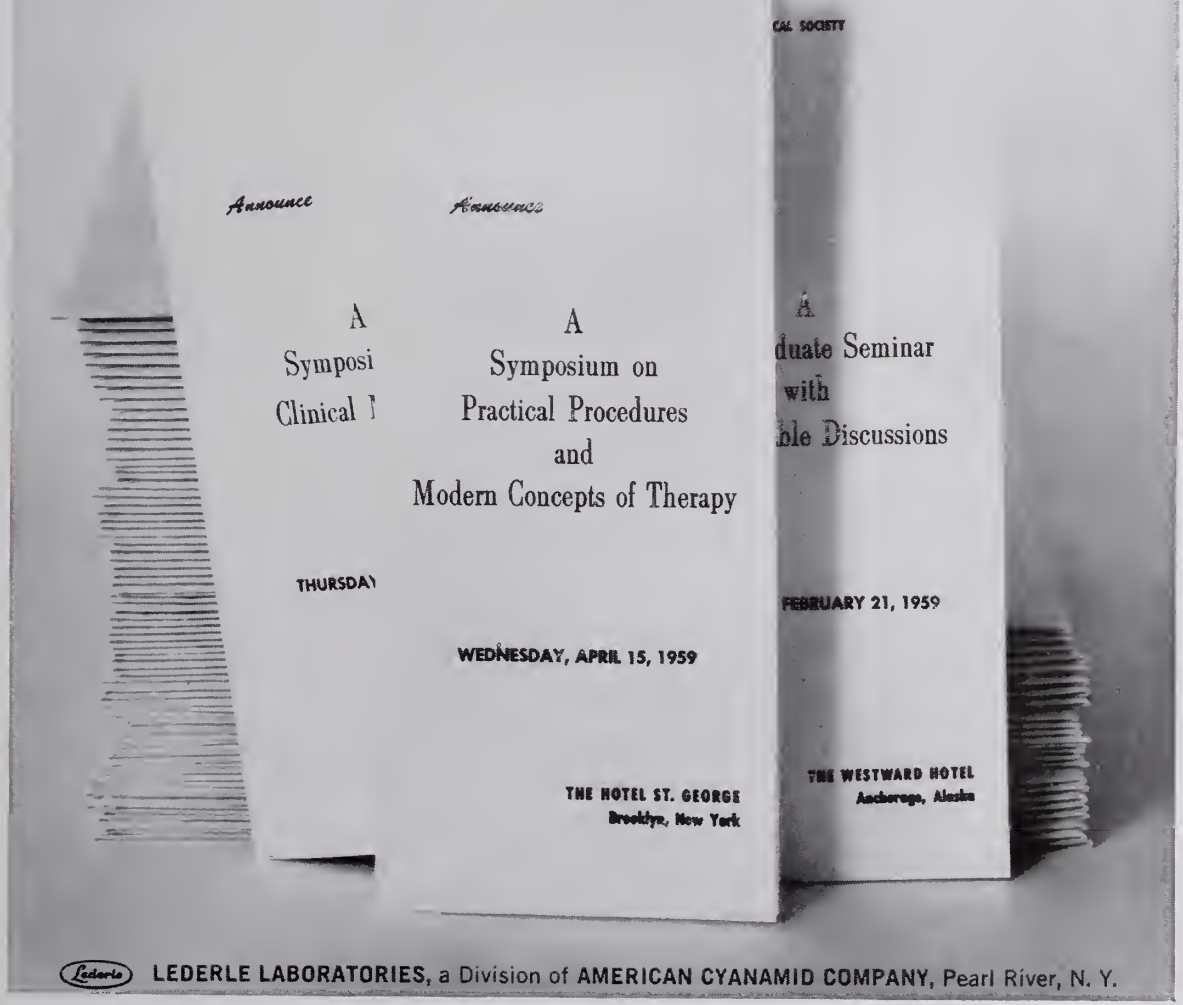
SCHENECTADY, NEW YORK—Thursday, November 12, 1959
The Mohawk Golf Club

CORPUS CHRISTI, TEXAS—Friday, November 13, 1959
The Robert Driscoll Hotel

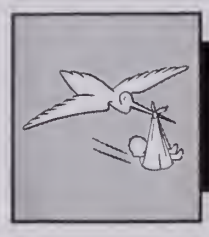
RIVERSIDE, CALIFORNIA—Sunday, November 15, 1959
The Mission Inn

SANTA BARBARA, CALIFORNIA—Wednesday, Nov. 18, 1959
The Santa Barbara Biltmore

MOLINE, ILLINOIS—Wednesday, December 2, 1959
The LeClaire Hotel



Lederle **LEDERLE LABORATORIES**, a Division of **AMERICAN CYANAMID COMPANY**, Pearl River, N. Y.



From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



Case #46: This patient was a 32-year-old married white gv 2 para 1 who was seen by a private physician initially with this pregnancy in her 6th month. Her past medical, surgical and obstetrical history was negative. Her L M P was November 28, 1957 and by menses she was due September 5, 1958.

She had a normal pregnancy until the 19th of August when she had an initial espisode of vaginal bleeding. This was described as very slight vaginal spotting. She consulted her physician and he had her go to bed and instructed her to call if the bleeding should increase. The next morning around 7:30 A.M. the patient called saying she had started bleeding profusely. She was told to go immediately to the hospital but though she lived only ½ a mile from it she didn't arrive there until 9:45 A.M.

Examination on admission revealed a patient of approximately 37 weeks gestation not in labor. The fetal heart was good. She was typed and cross matched for 1000 cc blood. Vaginal examination revealed the cervix 1 cm dilated with what was thought placenta previa centralis.

An immediate classical cesarean was done. No mention was made of the type of anesthetic. A 7 pound, 2 ounce girl was delivered in good condition. No complications were encountered during the surgery. The patient received 500 cc whole blood and 100 cc 5% G/W. The first two postoperative days were uncomplicated. The temperature ranged from 98° to 99°, the urinary output was good, pulse 80 and respirations 20.

On the third postoperative day the patient complained of chills and pain over the right kidney region. Her temperature was 102.6, pulse 100. A catheterized urinalysis and blood count was obtained. The Hb was 9.5 grams, WBC 10,000. Urine 15 pus cell, 15 RBC per high power field. Oral fluids were forced and she was started on Achromycin V®250 mg q 6 hours and combiotic 1 amp B.I.D.

The next day (4th PO) she appeared improved; she had less flank pain. Her temperature was 100, pulse 90, respirations 20. Her abdomen was soft, but slightly distended. She stated she was passing flatus. Her appetite was fair, she had no nausea or vomiting. She was started on Kynex® in addition to the other medication.

Her temperature was normal on the 5th PO day, pulse 80, respirations 20. She had no abdominal pain and the abdomen was soft; however, it was still slightly distended. Patient claimed she was still passing flatus. She also had some vomiting. An enema was given plus i.v. fluids, 1000 cc 5% G/W with lyo BC and 1000 cc 5% G/S.

The next day, 6th PO, the temperature was elevated 101°, pulse 110, respirations 50. The patient appeared to have some difficulty breathing and her abdomen was more distended. There was no mention of vomiting. Intravenous fluids were repeated as of the 5th day. Wagenstein suction was used. An x-ray of the chest was essentially negative, x-ray of the abdomen was read as possible ileus or partial obstruction of the small bowel.

No data was given for the 7th PO day.

The 8th PO day the temperature remained 101°, pulse 120, respirations 90. She again had difficulty breathing and the abdomen was more distended. She complained of no pain. The operative site was examined; there was no evidence of infection, a pelvic examination was done and was negative. A urinalysis, CBC and repeat x-rays of chest and abdomen were obtained plus medical consultation.

The chest x-ray was normal, the ileus remained and the Wagenstein suction was started again. She began to breathe more easily as the distention lessened.

The consultant felt clinically the patient had a paralytic ileus. There were no particular signs of localizing sepsis in either the abdomen or chest. He felt there was a questionable electrolyte balance. The tachycardia he felt was unusual, and may have been from the anemia or in part from the patient's apprehension.

Ninth PO day. The patient's T P R continues to rise, her breathing was labored. At one time the temperature was 103°, pulse 150, respirations 76. She remained alert and stated she had no pain.

She was placed in an O_2 Tent, 3000 cc of travert #1 was given with 40 meg of KCL in each 1000 cc and 500 cc of whole blood was given when the repeated Hb was found to be 9 grams. Achromycin was given i.v. because the suction at this time had some blood in the tube.

Tenth PO day. Her temperature rose to 105°, the pulse was very rapid and irregular, respirations were very labored. Ice baths and ice bags were used to lower the temperature. Approximately 5 hours after the temperature of 105°, it suddenly dropped to 99.2°. The pulse became slower and weaker and the respiration more irregular. She was able now to respond only with difficulty and expired 4:45 A.M. August 29. Autopsy revealed

Respiratory System

Bilateral pulmonary abscesses plus acute bronchopneumonia, staphyloccal pneumonia and pulmonary edema

Cardiovascular System

Abscesses of the myocardium

(Continued on Page 878)



when pollen allergens attack the nose...

Triaminic provides more effective therapy in respiratory allergies because it combines two antihistamines[1, 2] with a decongestant.

These antihistamines block the effect of histamine on the nasal and paranasal capillaries, preventing dilation and exudation.[3] *This is not enough;* by the time the physician is called on to provide relief, histamine damage is usually present and should be counteracted.

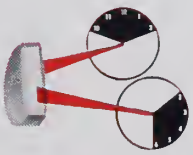
The decongestive action of orally active phenylpropanolamine helps contract the engorged capillaries, reducing congestion and bringing prompt relief from nasal stuffiness, rhinorrhea, sneezing and sinusitis.[4, 5]

TRIAMINIC is orally administered, systemically distributed and reaches *all* respiratory membranes, avoiding nose drop addiction and rebound congestion.[6, 7] TRIAMINIC can be prescribed for prompt relief in summer allergies, including hay fever.

References: 1. Sheldon, J. M.: Postgrad. Med. 14:465 (Dec.) 1953. 2. Hubbard, T. F. and Berger, A. J.: Annals Allergy p. 350 (May-June) 1950. 3. Kline, B. S.: J. Allergy 19:19 (Jan.) 1948. 4. Goodman, L. S. and Gilman, A.: Pharmacol. Basis Ther., Macmillan, New York, 1956, p. 532. 5. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 6. Lhotka, F. M.: Illinois M.J. 112:259 (Dec.) 1957. 7. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

Triaminic®

TRIAMINIC provides around-the-clock freedom from hay fever and other allergic respiratory symptoms with just one tablet q. 6-8 h. because of the special timed-release design.

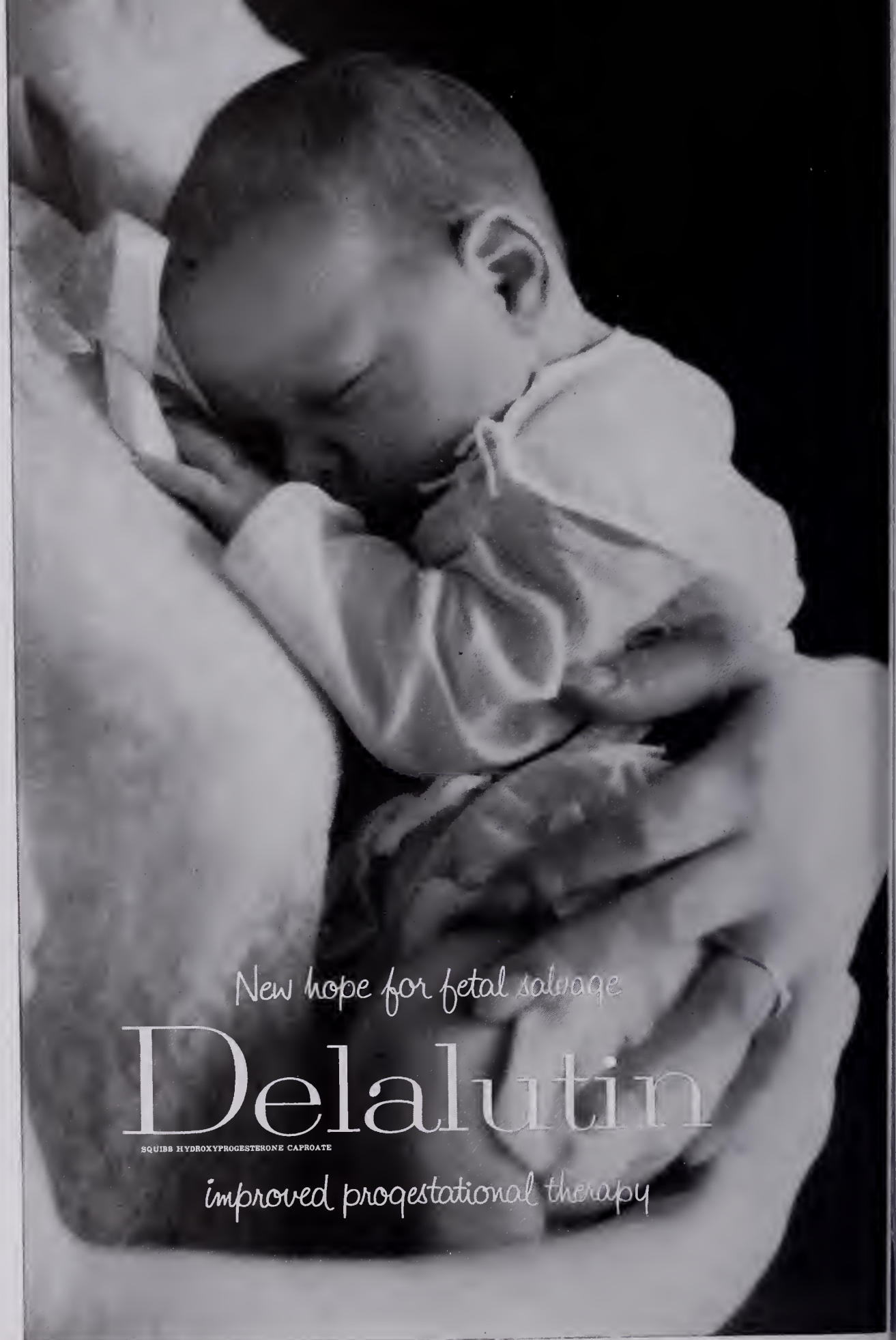


Each TRIAMINIC timed-release tablet provides:
Phenylpropanolamine HCl.....50 mg.
Pheniramine maleate.....25 mg.
Pyrilamine maleate.....25 mg.

Also available: TRIAMINIC SYRUP for those patients of all ages who prefer a liquid medication. Each 5 ml. teaspoonful is equivalent to ¼ Triaminic Tablet or ½ Triaminic Juvelet. TRIAMINIC JUVELETS provide half the dosage of the Triaminic Tablet with the same timed-release action for prompt and prolonged relief.

STOP *running noses*  *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada


New hope for fetal salvage
Delalutin
SQUIBB HYDROXYPROGESTERONE CAPROATE
improved progestational therapy

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein.[1] Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy
64% of 42 pregnancies were salvaged by progesterone
83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that with Delalutin fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved.
108 (76%) of 142 babies of this birth weight survived without progestational therapy.
16 (100%) of 16 babies of this birth weight survived with Delalutin therapy.
A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active," well-tolerated and long-acting.

Delalutin offers these advantages over other progestational agents:

- longer-acting and more sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requires injection of less vehicle
- unusually well-tolerated, even in large doses
- requires fewer injections
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum after-pains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and Dosage: Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply: Delalutin is available in vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

References: 1. Reifenstein, E. C., Jr.: *Annals N. Y. Acad. Sci.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. and Gyn.* 76:279, 1958.

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PUBLIC HEALTH PAGE

Poliomyelitis Immunity Status In Kentucky Communities

RUSSELL E. TEAGUE, M.D.
Commissioner of Health, Commonwealth of Kentucky

Despite the proven safety and effectiveness of Salk Poliomyelitis vaccine, far too many persons throughout the country and our State remain unvaccinated. In order to pinpoint groups and areas where immunization levels are low, the Communicable Disease Center, Atlanta, has designed a manual for conducting poliomyelitis immunity surveys in urban areas. Through such surveys, made at the local level, communities are able to develop immunization programs that will fill their particular needs.

Kentucky has the distinction of being the only State to have more than one such survey and the only State to include rural territory in a poliomyelitis immunity study.

Results to date have created an awareness and concern among physicians, as well as public health officials, as to the severity of the problem. Although Kentucky has had relatively few cases reported this year, the low immunization status of her people presents a definite potential for outbreaks throughout the State.

Surveys have already been conducted in Lexington and Ashland, and another, covering Louisville and Jefferson County, is due for completion August 1. Interviewing was done by Health Department personnel in Lexington and Ashland; two senior medical students have been employed for the survey in Louisville and Jefferson County.

The first step in a survey of this type is division of the city into census tracts according to the 1950 Population Census Report. Information is obtained on the current city limits and corrections are made in the boundaries of the census tract map. Estimates of population or number of dwelling units for each census tract are also necessary. A dwelling unit is defined as living quarters which have separate cooking equipment or a separate entrance.

The census tracts are then ranked according to a socioeconomic index based upon median school years completed by the head of the household, per cent of dwelling units with 1.01 or more persons per room, and per cent of dwelling units with delapidated or no private baths. The top 25 per cent of the tracts are classified as upper, the central 50 per cent as middle, and the lowest 25 per cent as lower socioeconomic areas. This differentiation of a city's population into socioeconomic strata on a geographical basis is important for two reasons: (1) the immunization status of children is closely related to the attitudes and financial resources of the family, and (2) the desirability of basing immunization campaigns on geographic areas.

A minimum of 20 sample points for each socioeconomic group is selected with the use of a table of random numbers. These points are distributed among the census tracts in proportion to the population. The street intersection nearest the random point becomes the sampling point, and four sample dwelling units are selected at random from the houses within one block of the intersection.

Data obtained at each interview include name, age, and sex of each member of the household, polio vaccination status of each person, number of rooms, number of baths, education of the head of the household, and whether the family calls upon a particular physician. Reasons for non-immunization of persons under 20 are also requested. The Ashland and Louisville-Jefferson County surveys include a question as to DPT immunization status of each child under six.

Results of the surveys already completed are similar: persons in the lower socioeconomic groups are generally inadequately immunized, particularly preschool children, who are only 20 per cent immunized. Over-all protection rates for both cities have been calculated, as follows:

Age Group	Lexington	Ashland
0-4	43.8%	44.7%
5-14	68.4%	75.0%
15-39	34.1%	30.0%
Over 40	4.0%	4.0%
Total population under 40	38.7%	46.5%

The surveys have caused widespread interest in polio vaccination programs. In Lexington, for example, the Fayette County Medical Society has endorsed free vaccination for indigents. The City of Lexington donated $1,000 for the purchase of Salk vaccine, and an additional $1,000 has been earmarked by the Fiscal Court for this purpose. The county school board has an allocation under consideration.

(Continued on Page 878)



Prompt 4 way check of DIARRHEA

POMALIN TRADEMARK Liquid

New **RASPBERRY FLAVOR**

and pink color make POMALIN pleasant to take and appealing to both children and adults.

- ✓ Curbs excessive peristalsis
- ✓ Adsorbs toxins and gases
- ✓ Soothes inflamed mucosa
- ✓ Provides intestinal antisepsis

FORMULA:

Each 15 cc. (tablespoon) contains:

Sulfoguanidine	2 Gm.
Pectin	225 mg.
Kaolin	3 Gm.
Opium tincture	0.08 cc.
(equivolent to 2 cc. paregoric)	

SUPPLIED:

Bottles of 16 fl. oz.
Exempt Narcotic.
Available on Prescription Only.

DOSAGE:

ADULTS: Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

CHILDREN: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
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avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4,5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2,4,5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage

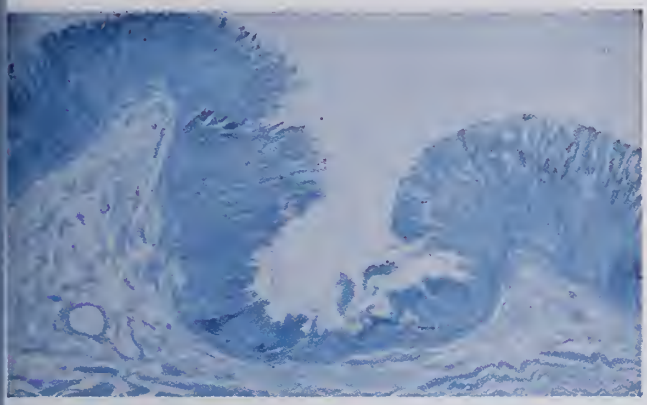


Regular aspirin crystals 24 hours after being mixed into water.

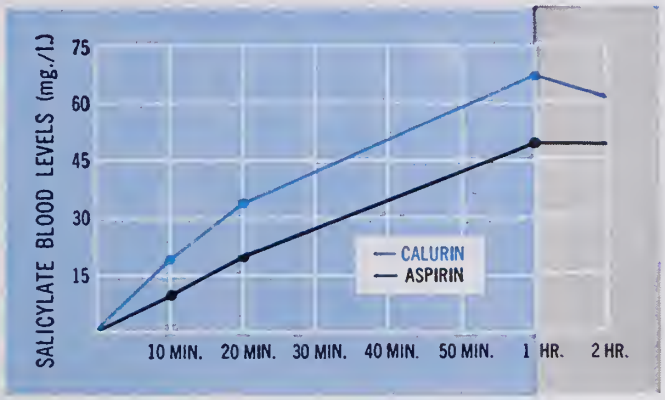
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

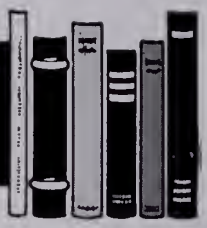
REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. **2**:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet **2**:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. **80**:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. **2**:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet **1**:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology **33**:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. **258**:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. **258**:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. **1**:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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IN THE BOOKS



LONG TERM ILLNESS: MANAGEMENT OF THE CHRONICALLY ILL PATIENT: edited by Michael G. Wohl, M.D.; published by W. B. Saunders Company, Philadelphia and London, 1959; 748 pages; price, $17.

This book has its aim "to present in one volume a comprehensive survey of the patient with prolonged illness." To achieve this aim the Editor has compiled a series of chapters written by qualified authorities in each of the various fields selected. The contents are divided into "Part I—General Principles" and "Part II—The Therapy of Specific Diseases."

Part I is a brief section of only ninety pages in which the problems of hospitalization for long term illness, home care, rehabilitation, psychologic problems of the clinically ill and nursing procedure are discussed. While the articles are interesting, they do not explore these broad subjects as thoroughly as one might wish in a book devoted to the subject of long term illness.

Part II, a section of about seven hundred pages, contains some excellent articles on the therapy of a great variety of diseases. Unfortunately, a large number of diseases do not lend themselves to brief reviews of therapy. It is impossible to gain a worthwhile understanding of therapy in most complicated diseases without connecting the therapy directly, and in detail, to pathologic physiology. If this is done too briefly the result is too superficial to accomplish its purpose. An attempt was made in this book to indicate the basis for therapy outlined, but the amount of ground covered has lead in many instances to the inevitable result.

One wonders whether any real goal is accomplished by collecting brief treatises on therapy of a large and varied group of diseases having no other connection than the fact that they may last for a long time.

William A. Blodgett, M.D.

THE ANATOMY OF THE NERVOUS SYSTEM. ITS DEVELOPMENT AND FUNCTION: by Stephen Walter Ranson, M.D., Ph.D., and Sam Lillard Clark, M.D., Ph.D., published by W. B. Saunders Company, Philadelphia and London, 1959; 622 pages; price, $9.50.

"The charm of neurology, above all other branches of practical medicine, lies in the way it forces us into daily contact with principles. A knowledge of the structure and function of the nervous system is necessary to explain the simplest phenomena of disease, and this can only be attained by thinking scientifically" (Henry Head). No more fitting quotation could be made by the authors than this one which heralds Chapter XXI entitled Clinical Illustrations. These sentences epitomize the work initiated by the late Dr. Ranson and so meticulously followed by Clark.

This volume, originally published in 1920, has from its very beginning been a standard to the undergraduate and postgraduate student, be he a bibliophile or a perennial beginner. Subsequent editions (the present is its tenth) have succeeded only in enhancing its value.

The book can be termed an analysis of dynamic neuroanatomy or correlative clinical neurophysiology. Description of anatomic areas and nervous pathways can be deadly boring to neophyte and scholar alike. However, the student's appetite is whetted and his intellectual gastronomic delights are rendered immeasurable by the authors' constant adherence to the dictum of functional exploration. This functional correlation is conscientiously traced not only from a horizontal but from a longitudinal (evolutionary, comparative anatomy) standpoint.

The volume is updated with exemplary clinical illustrations and case discussions, which after all, is the ultimate goal of the clinician. Yet, the anatomist and physiologist is not neglected. The descriptive material is lucid, the anatomical sections of the brain are excellent and the references are complete enough to act as an ideal stepping stone for the research minded.

This book, regardless of the edition, is really an ageless one. There are few texts in any field of medicine which this reviewer could recommend for one's personal library, but this one would certainly approach the top of the list.

Ephraim Roseman, M.D.

HANDBOOK OF CARDIOLOGY FOR NURSES: Third Edition; by Walter Modell, M.D., and Doris R. Schwartz, R.N.; Springer Publishing Co., N. Y.; 1958; 328 pages; $4.50.

This is more than a handbook, it is a treatise on cardiology designated for nurses, and aimed specifically toward nurses specializing in cardiac nursing.

This book has 300 pages of cardiology. It is done in a clear, uncluttered style and presents the entire field of clinical cardiology in simple terminology but in great detail. It is a splendid reference book for nurses and there is undoubtedly a great need for this book. It is too comprehensive to be used as a standard text for nursing students and probably too elementary for medical students.

The nurse who is handling cardiac patients will find this a great source of ready information, well indexed and easy to read. The authors anticipate the nurses problems and answer her questions in a detailed and reassuring manner. The role of the nurse in an acute emergency is especially well discussed and it should be a comfort to both patient and doctor to know that the nurse has a clear cut understanding of her responsibilities.

I would recommend physicians to keep a copy of this book on hand, and encourage nurses to read it when they are in contact with cardiac nursing cases.

F. Albert Olash, M.D.



A Vacation from Hay Fever is a Real Vacation

ANYWHERE – ANYTIME

Just a "poof" of fine **NTZ** *spray brings relief* IN SECONDS, FOR HOURS

NTZ is a potentiated, balanced combination of these well known synergistic compounds:

Neo-Synephrine® HCl, 0.5%
– dependable vasoconstrictor and decongestant.

Thenfadil® HCl, 0.1%
– potent topical antihistaminic.

Zephiran® Cl, 1:5000
– antibacterial wetting agent and preservative.

NTZ® NASAL SPRAY

Supplied in leakproof, pocket size squeeze bottles of 20 cc.



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MATERNAL MORTALITY PAGE

(Continued from Page 868)

G. I. System

Multiple hepatic abscesses plus acute fibrino purulent peritonitis

G. U. System

Acute suppurative nephritis with multiple visceral abscesses. Bacteriology obtained at autopsy revealed micrococcus pyogenes variety aureous (hemolytic) phage 80/81

The cause of death was given as cardio respiratory failure due to multiple abscesses of the liver and lungs due to septicemia following cesarean section.

Comment

The committee felt that this case was most unusual and tragic and certainly worthy of the attention of the entire profession. Though the questionnaire was unusually complete, the sourse of contamination was not known until this case was presented. The operating room where the emergency section was done was used to drain an undetermined abscess earlier that morning. The committee felt this case was non-preventable as far as the patient and the physician were concerned, however, the hospital policy should have insisted on complete decontamination of the room for at least 24 hours before the room was used for the next case.

Even with the host of miracle drugs we now have available, prevention is still paramount.

PUBLIC HEALTH PAGE

(Continued from Page 872)

Both the Lexington and Ashland Health Departments have reported a tremendous increase in requests for polio vaccine as a result of the interest aroused by the surveys.

A survey of rural areas in Kentucky is being considered, and it is hoped that such a survey will better show the reasons for non-immunization. Procrastination was by far the main reason given by middle and lower socioeconomic groups in both completed surveys. If accessibility is not a prime factor, a rural survey should give essentially the same results as the urban surveys even though there would not be as great a differentiation among income groups as appeared in the cities.

If, through surveys such as the ones described, the vaccination needs of particular groups and areas can be determined, and educational methods to counteract the attitudes which keep people from being vaccinated can be devised, the goal of the highest possible level of protection against polio can be attained.



provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
WHENEVER SULFAS ARE INDICATED ®
KYNEX
Sulfamethoxypyridazine Lederle
0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
LEDERLE LABORATORIES, a Division of
AMERICAN CYANAMID COMPANY, Pearl River, New York

PERTINENT PARAGRAPHS

The World Medical Association has made initial arrange-ments for providing its participants at the Second World Conference on Medical Education in Chicago, August 30-September 4 and the World Medical Association 13th General Assembly on September 7-12 with a special chartered transportation plan, according to Louis H. Bauer, Secretary General of the World Medical Association. Members of the national medical associations and their families are eligible to apply for reservations on the chartered flights. Additional information may be obtained from: The World Medical Association, 10 Columbus Circle, New York 19, N. Y.

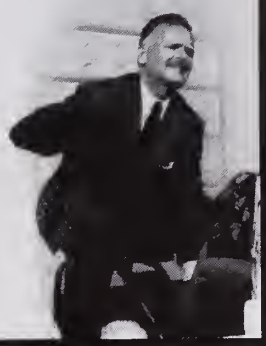
The Women's Hospital Division of St. Luke's Hospital in New York City offers a one week course in "The Conduct of Labor and Delivery" from October 8 through 14 which will be acceptable for thirty hours of Category I credit for general practitioners. Enrollment for the course will end on September 15, 1959. If interested, write: Mr. Carl P. Wright, Jr., Director, Women's Hospital, 141 West 109th St.,

About one-third of the approximately 7000 new phy-sicians being produced by the U. S. yearly receive training in Veterans Administration Hospitals, according to Sumner G. Whittier, Administrator of Veterans Affairs. Mr. Whittier said medical training is conducted in VA hospitals primarily for its effect in raising the quality of care furnished veteran-patients, and in helping to recruit scarce category personnel for the hospital staffs.

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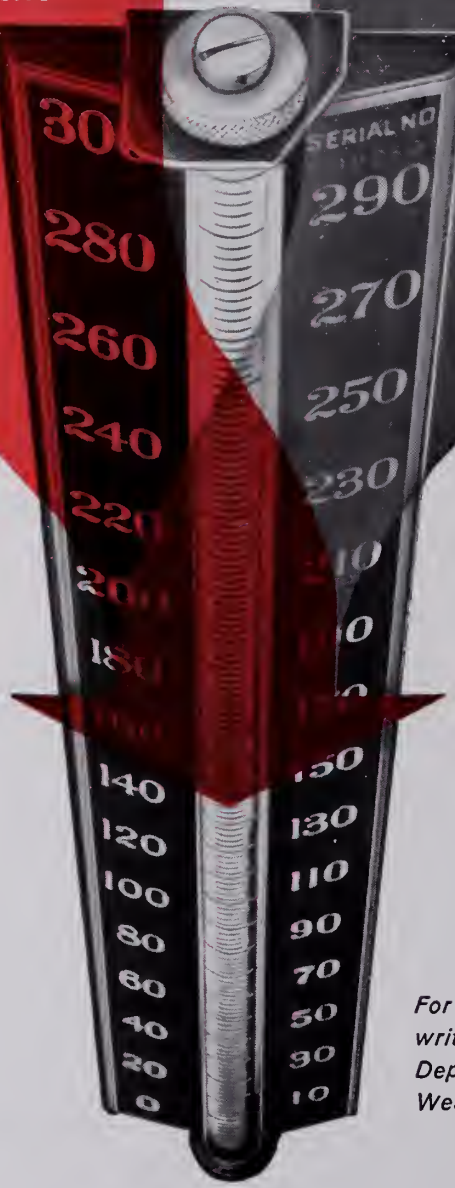
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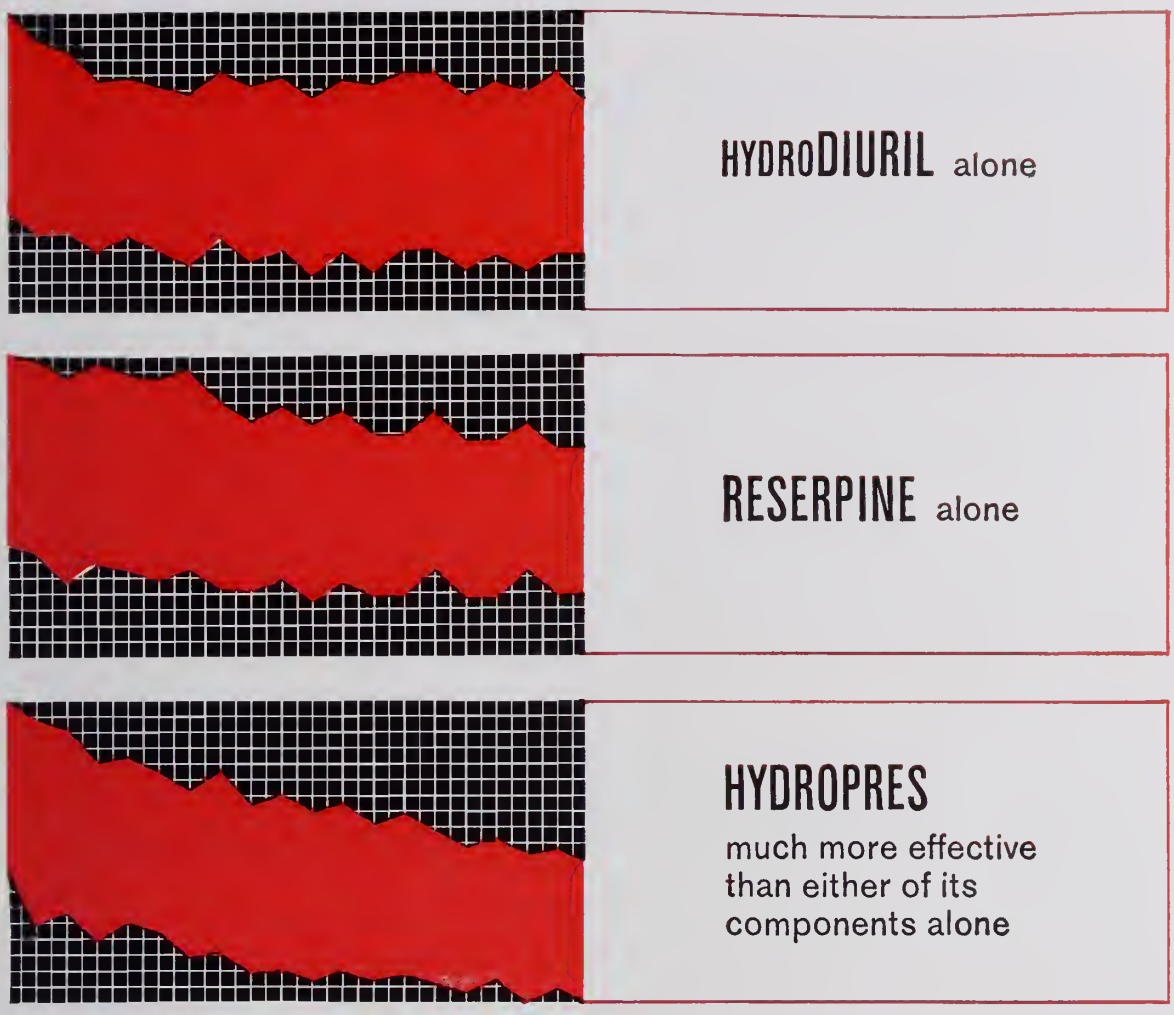
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(1) Rubin, A., and Babbott, D.: J.A.M.A. *168*:498, (Oct. 4) 1958. (2) Kinsey, A. C.; Pomeroy, W. B., and Martin, C. E.: Sexual Behavior in the Human Male, Philadelphia, W. B. Saunders Company, 1948.

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The JOURNAL of the Kentucky State Medical Association

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KENTUCKY STATE MEDICAL ASSOCIATION
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AUGUST 1959 · VOLUME 57 · NUMBER 8



in epilepsy

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bibliography: (1) Carter, S. M.: *M. Clin. North America:* 315 (March) 1953. (2) Chao, D. H.: *Ibid.*, p. 465. (3) Goodman, L. S., & Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, MacMillan Company, 1955, p. 187. (4) Davidson, D. T., Jr., in Conn, H. F.: Current Therapy 1958, Philadelphia, W. B. Saunders Company, 1958, p. 568. (5) Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955. (6) French, E. G.; Rey-Bellet, J., & Lennox, W. G.: *New England J. Med.* 258:892 (May 1) 1958.



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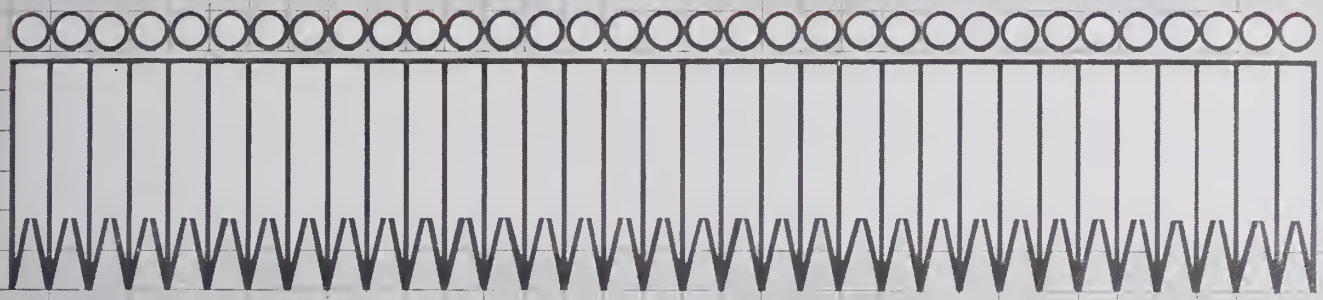
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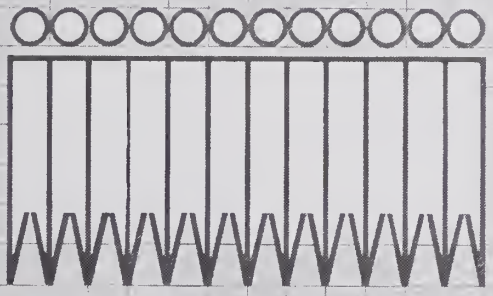
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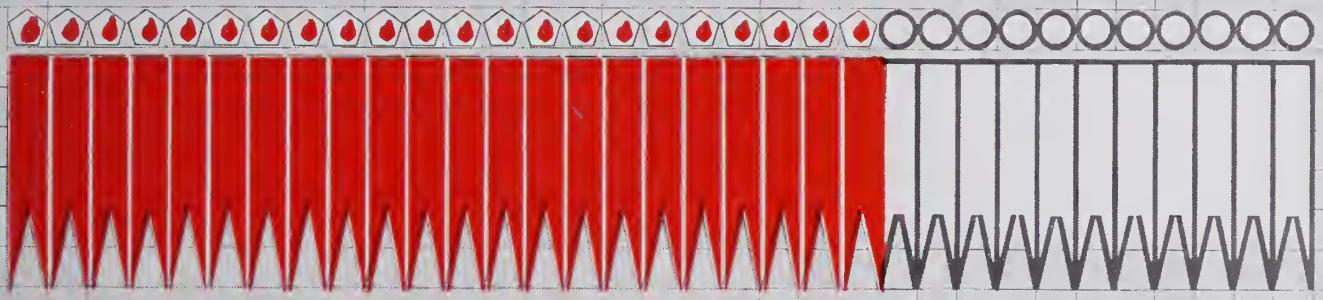
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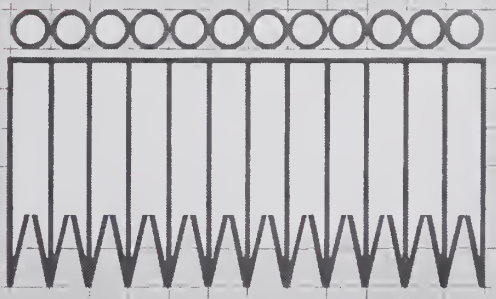


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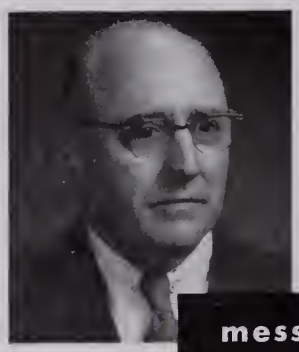
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message from the President

AS you all know medicine has made greater progress since the turn of the century than it had made since the beginning of time. Are we resting on our laurels, or will this great progress go on and on?

In scanning the literature one finds information that should give us cause for serious thought. For example in 1941, the federal government contributed slightly over forty thousand dollars to our medical schools for research. In 1952, the total federal contribution to medical research was thirty-six million dollars and it is estimated that this year around two hundred and six million dollars will be contributed. Part of this money will be spent within the Armed Services, Veterans Administration, Public Health Service, and other government agencies, but the great bulk will be allotted for research within our universities and hospitals. Added to this there will be approximately one hundred and twenty-four million dollars of private funds appropriated, making a total of three hundred and thirty million dollars.

This is approximately two and two tenth per cent of our total bill for medical expenditures. Is this enough or too much? I can not answer this question, but I do know that money is not the only answer. With this money there should be people chosen who are dedicated to research. People who have demonstrated initiative, intellectual curiosity, scientific critique, and resourcefulness.

No large sums are needed for basic research. Consider the fundamental work of Albert Einstein and Neils Bahr in splitting the atom. Comparatively speaking brains predominated over money in getting this job done.

Certainly, a growth of over three hundred per cent, in the past five years, in Federal Funds for research, makes one think, "How far reaching is the destiny of medicine?"

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THE INSURANCE PAGE



Service Benefits

DEFINITION: The acceptance by physicians without additional charge, of payments in amounts they themselves have established, limited to services they themselves have delineated, and for patients whose incomes fall below limits they themselves have prescribed.

Let us assume at the outset that everyone reading these lines believes in the system developed by organized medicine for prepaying medical care. Most physicians realize that organized medicine is the Father of the Blue Shield movement and that its operation is directed by organized medicine. Many of us remember when the Kentucky State Medical Association formed our Kentucky Blue Shield Plan a short ten years ago. We organized this Plan because of the economics of paying for medical care and because we realized that if we did not develop a plan for helping finance medical care that Uncle Sam would do it for us. We have thereby retained for the medical profession the control and the direction of this prepayment mechanism. May we ever be thankful that our delegates were far-sighted enough to give birth to the Blue Shield Plans and thereby impede the march toward federalized medicine.

Medical Associations in other states also developed their Blue Shield programs, each relatively independent of the others. Approximately 75% of these Plans operate on the so-called partial service principle, and the remaining 25% on an indemnity basis.

The definition of service benefits, as provided in the first sentence of this article, means that the participating physician agrees to accept, without additional charge to the patient, the allowance established by physicians for services defined by physicians *if the annual income of the patient falls below the limit established by physicians and thereby prescribed in the patient's membership.* This allowance becomes an indemnity allowance on all patients whose incomes exceed this limit, and the physician merely agrees to credit this allowance toward whatever fee he chooses.

Management and Labor purchase medical care through some prepayment mechanism for more than 89,000,000 employees and their dependents. Spokesmen for these people are demanding a more uniform product than a mixture of 75% partial service and 25% indemnity, as is now offered. They are demanding, and are apparently willing to pay for, a prepayment plan which will provide full payment for covered services provided to employees in the lower income brackets. Indemnity allowances do not provide this assurance. The efforts of organized medicine should be directed toward development of a more uniform product which will provide this assurance. Such a product would offer us some hope of retaining the free practice of medicine.

What are the advantages of service?

It delivers to the low income patient specified medical care at a pretetermined figure. This amount is *established by* and agreed to in advance by the medical profession. (Relative Value studies similar to those in California may be necessary in order to establish equitable allowances for various services and procedures.)

This type of program is what the public wants. (History indicates that what the public wants, they will eventually get, one way or another.)

It provides assurance to the low income patient that, if he is willing to pay for it, he may purchase full prepaid protection for covered services if and when he needs them; that if he sets aside a portion of his income as he earns it to meet his responsibility to his doctor, that charges for services rendered to him or his family will not be increased because he has protection.

The profession retains control of the services they provide.

Recognition is given to the changing economics of financing medical care. (Very few people today can meet the mounting costs of serious illness out of savings, therefore they attempt to budget in advance through prepayment plans.)

It is a program participation in which it is voluntary on the part of the patient and on the part of the physician to combat closed panel and government medicine.

To conclude: Many of us believe that this change is necessary. By holding on to our actuarially safe, but less salable, complete indemnity plan, we fear that we are being short-sighted and impeding the progress of our doctors' plan.

We believe that the profit motive inherent in private insurance companies without the self policing inherent in our own mode of operation would most surely result in higher and higher premiums, and thereby hasten the entrance of full closed panel and government medicine.

We believe that the free practice of medicine, as most of us still know it today, hinges directly upon the success of the plan devised by organized medicine. The change to service is recommended in order to strengthen the stand of organized medicine, which is free medicine.

GARNETT J. SWEENEY, M.D.
Liberty

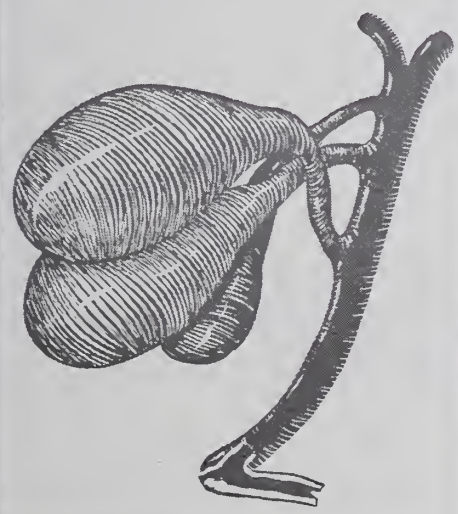
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HOW PREVALENT ARE MULTIPLE GALLBLADDER ANOMALIES?

One hundred and twenty-two cases of *vesica fellea divisa* (bilobed gallbladder) and *vesica fellea duplex* (double gallbladder with 2 cystic ducts) are reported in the literature. A unique case of *vesica fellea triplex* has recently been described.

Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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plus reliable spasmolysis

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"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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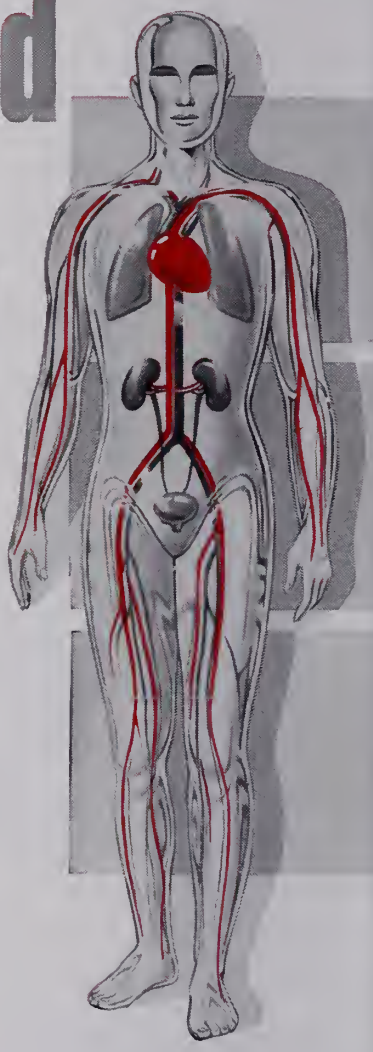
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*it's as easy as 1, 2, 3 to use

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Supplied: 25 mg. and 50 mg scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000.
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NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involutional melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic-depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, when due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

New safety

The outstanding safety of NIAMID in extensive clinical trials eliminates the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these model depressions is seen with a rise in the levels of both serotonin and norepinephrine.

A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

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PFIZER LABORATORIES

Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.



Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

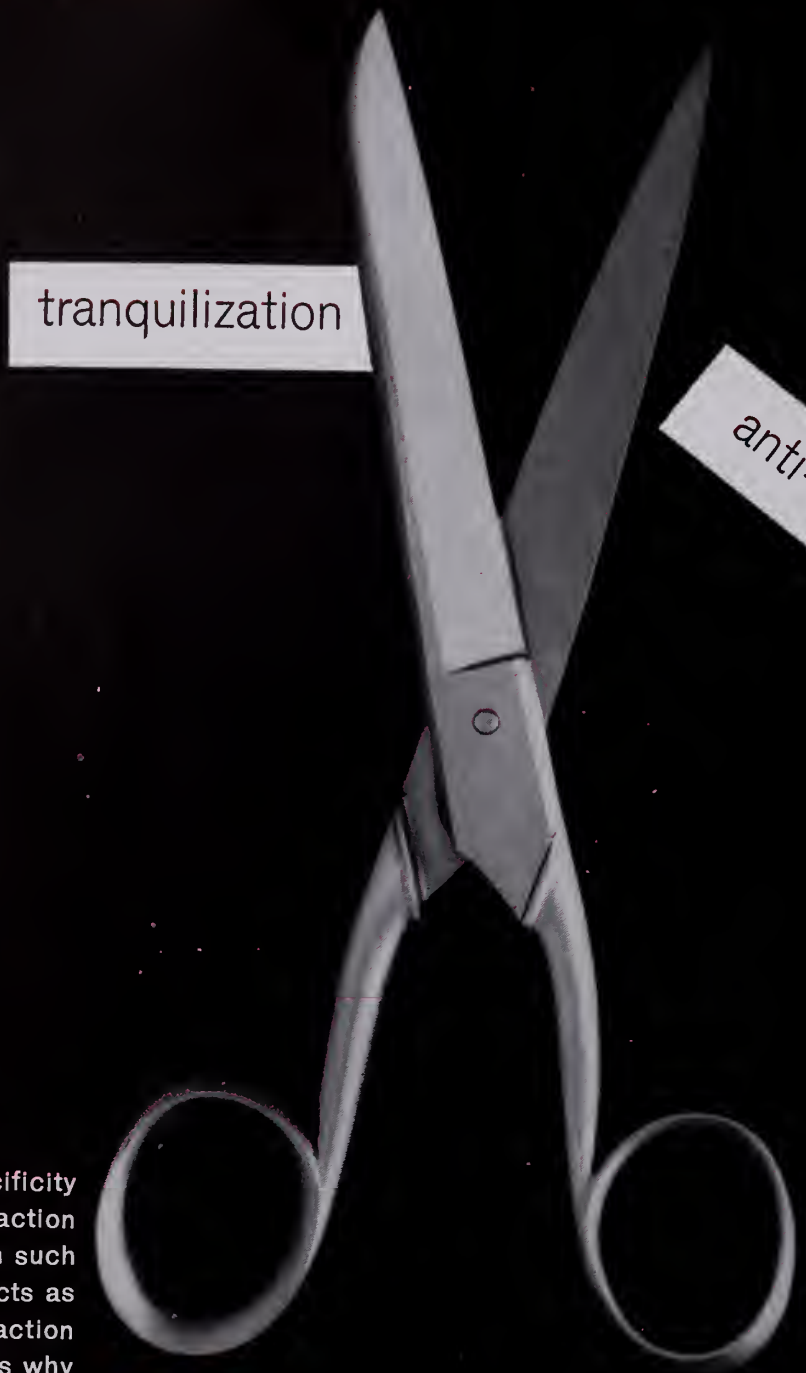
Complete bibliography and Professional Information Booklet are available on request.

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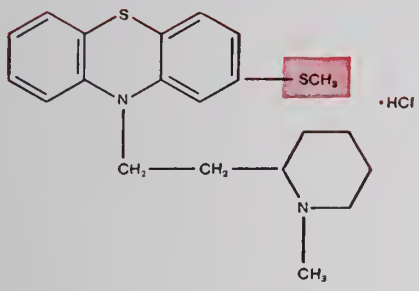
Mellaril®

THIORIDAZINE HCl

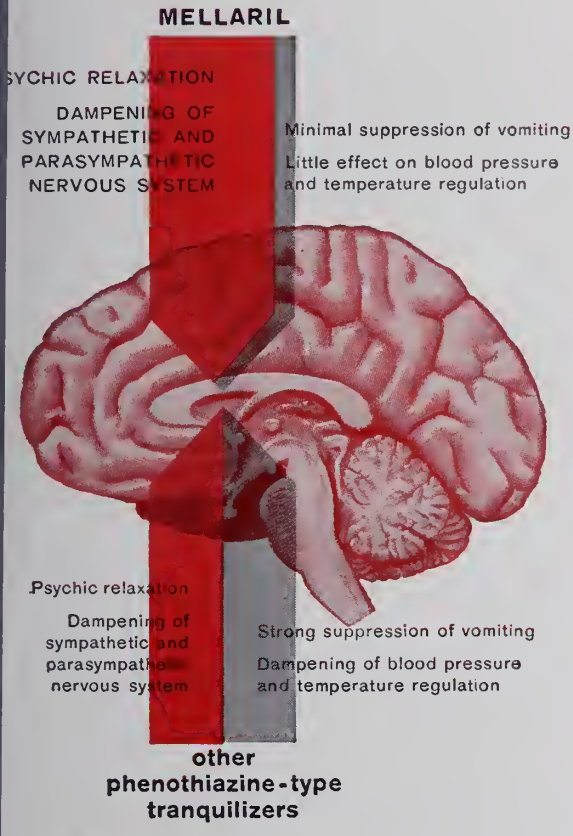
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. ... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

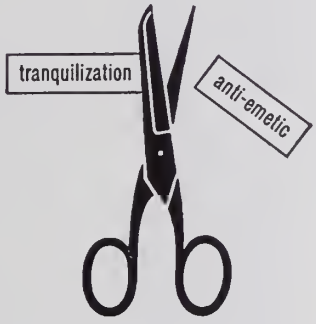
new advance in tranquilization:
greater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S-CH_3) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

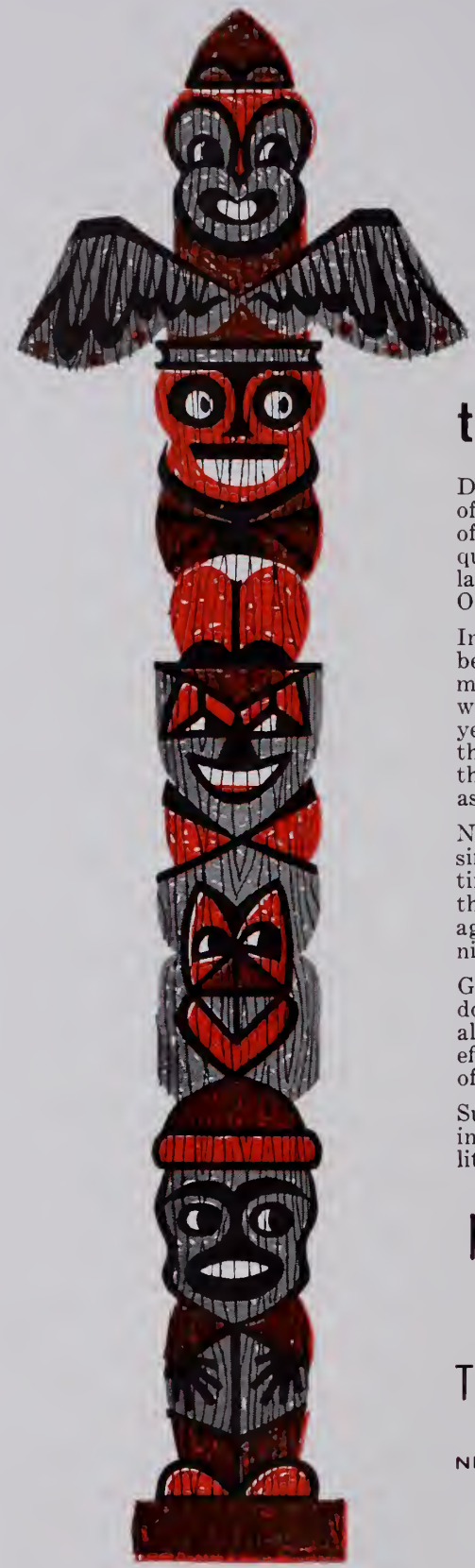
5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

*Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959

SANDOZ



the disease of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is "one of the most widespread and serious protozoan diseases of man," yet "there is no parasite more often misdiagnosed than is *E. histolytica*." Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

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Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

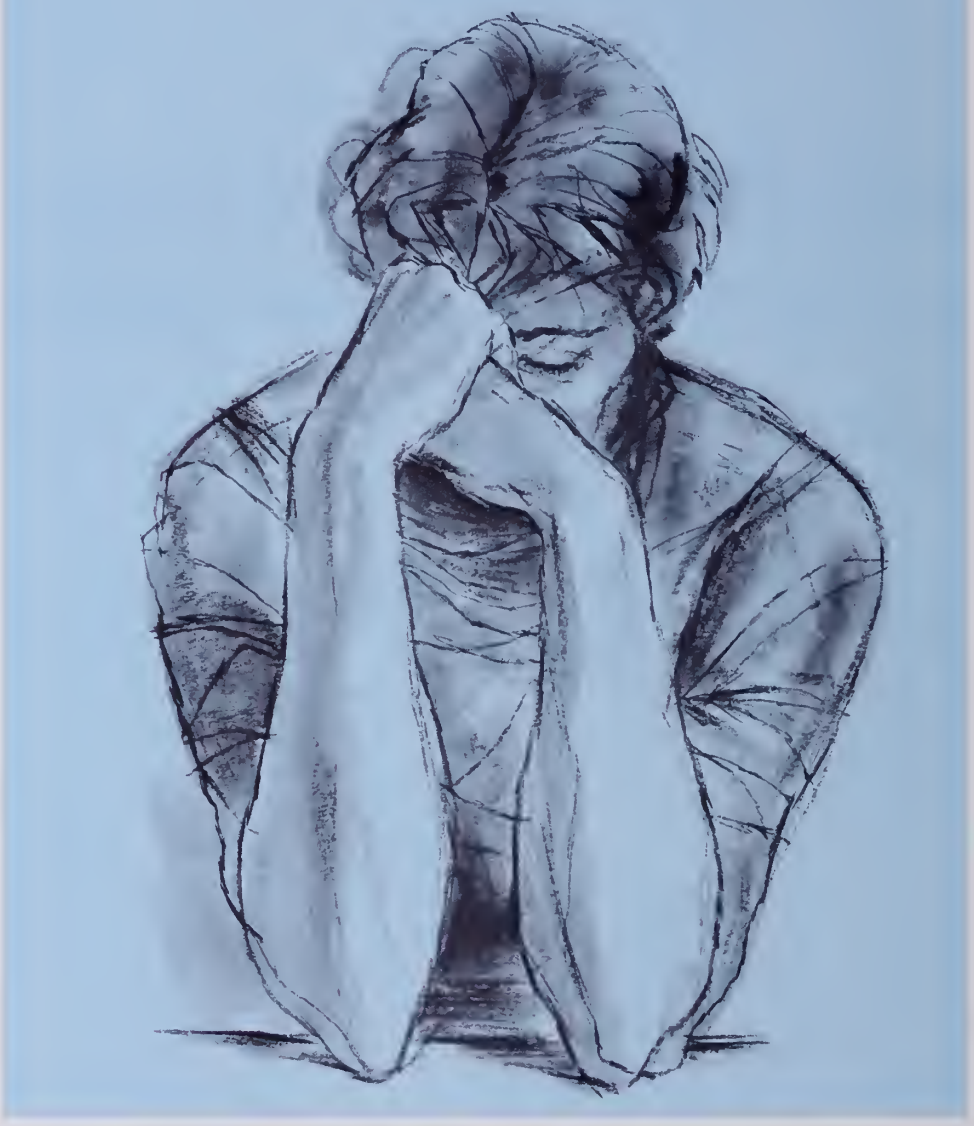
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1. Pennington, V. M.: Meprobamate (Miltown) in premenstrual tension. J.A.M.A. 164:638, June 8, 1957.

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WASHINGTON NEWS DIGEST



Washington, D. C.—President Eisenhower's power of veto has been a powerful weapon in his fight against big spending programs of the Democrats.

His outstanding use of the power so far in this session of Congress was the veto of the Democratic, catch-all $1,375,000,000 housing bill. Mr. Eisenhower said the measure was extravagant and inflationary. He warned that the fight against inflation could not be won "if we add one spending program to another without thought of how they are going to be paid for and invite deficits in times of general prosperity."

The housing bill included three provisions of interest to the medical profession. One provision, endorsed by the American Medical Association, would have authorized Federal Housing Administration guarantees of loans for construction of proprietary nursing homes. The second provision would have authorized direct federal loans for housing for interns and nurses. The third would have authorized both such loans and guarantees for housing for elderly persons.

Mr. Eisenhower objected to direct loans for housing for the aged. But he directed his main attack against the legislation's public housing and urban renewal provisions.

The President also vetoed a wheat price support bill which, he charged, "would probably increase . . . the cost of the present excessively expensive wheat program."

The threat of a veto also caused the Democrats to retreat and cut back their airport construction legislation.

These actions improved prospects for a balanced, or near-balanced, budget in the current fiscal year. Another factor working for a balanced budget is the economic upsurge which means more federal revenue than originally estimated.

But Congress voted more for medical research than the President wanted. However, all of it may not be spent because the President has the authority to hold back part of it.

The Senate voted $481 million and the House, $344 million, for the National Institutes of Health—as against $294 million requested by Mr. Eisenhower. It was mandatory that a House-Senate Conference Committee, in working out a compromise between the House and Senate figures, approve a larger amount than the President requested.

The House Ways and Means Committee held hearings on the controversial Forand bill which would finance medical and hospital care of the aged through the social security system. Witnesses for the medical profession vigorously opposed the legislation. Dr. Leonard Larson, Chairman of the AMA Board of Trustees, and Dr. Frederick C. Swartz, Chairman of the AMA Committee on Aging, presented the AMA's views.

Representatives of various state medical societies either testified or presented statements in opposition to the legislation which would be financed through higher social security taxes and which would cost about $2 billion a year.

On another legislative front, AMA witness—George M. Fister, M.D., a member of the AMA Board of Trustees and Chairman of the AMA Council on Legislative Activities, and Vincent W. Archer, M.D., a member of the AMA House of Delegates and the AMA Committee on Federal Medical Services—testified before the Senate Finance Committee in support of a House-approved bill (Keogh-Simpson) that would provide tax deferrals for self-employed persons who invest in qualified pension or retirement plans.

Dr. Fister testified that high taxes and inflated living costs make it "difficult for the self-employed person to set aside adequate funds for retirement without a tax deferment similar to that available for corporate employees."

Experts from 17 nations gave favorable reports on use of live polio virus vaccine at a week's conference sponsored by the World Health Organization and the Pan American Health Organization.

However, the 61 experts conceded in a statement summarizing the conference discussions that problems remain in use of the vaccine which is given orally. Their main concern was with "the very difficult problems in the development control and evaluation of the safety and effectiveness" of the live vaccine. They also recognized that "the use of a product that spreads beyond those originally represents a radical departure from present practices in human preventive medicine."

An advisory committee of the U.S. Public Health Service recommended a fourth shot of Salk polio vaccine as routine for children and adults under 40 years of age. The report also said that Salk vaccine shots could be beneficial for persons over 40 but was "less urgent" because they had polio less frequently than younger people.

Surgeon General Leroy E. Burney of the Public Health Service also issued an urgent warning that tragic polio outbreaks might occur this year if communities didn't push polio vaccination campaigns.

*** ***

The Medical Society of the District of Columbia adopted a relative value scale of fees expressed in units rather than dollars. The basic unit of 1.0 is

(Continued on page 1000)

re-evaluating tranquilizers?

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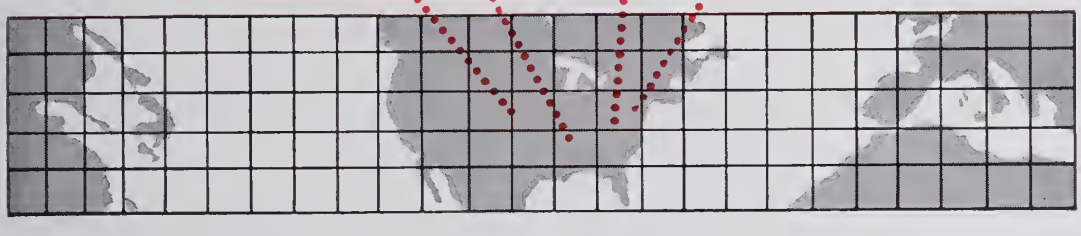
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For adult psychiatric and emotional emergencies	Parenteral Solution	25-50 mg. (1-2 cc.) intramuscularly, 3-4 times daily, at 4-hour intervals. Dosage for children under 12 not established.

Supplied: Tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Smigel, J. O., et al.: J. Am. Ger. Soc., in press. 2. Freedman, A. M.: Pediat. Clin. North America 5:573 (Aug.) 1958. 3. Ayd, F. J., Jr.: New York J. Med. 57:1742 (May 15) 1957. 4. Menger, H. C.: New York J. Med. 58:1684 (May 15) 1958. 5. Coirault, M., et al.: Presse méd. 64:2239 (Dec. 26) 1956. 6. Bayart, J.: Presented at the International Congress of Pediatrics, Copenhagen, Denmark, July 22-27, 1956.

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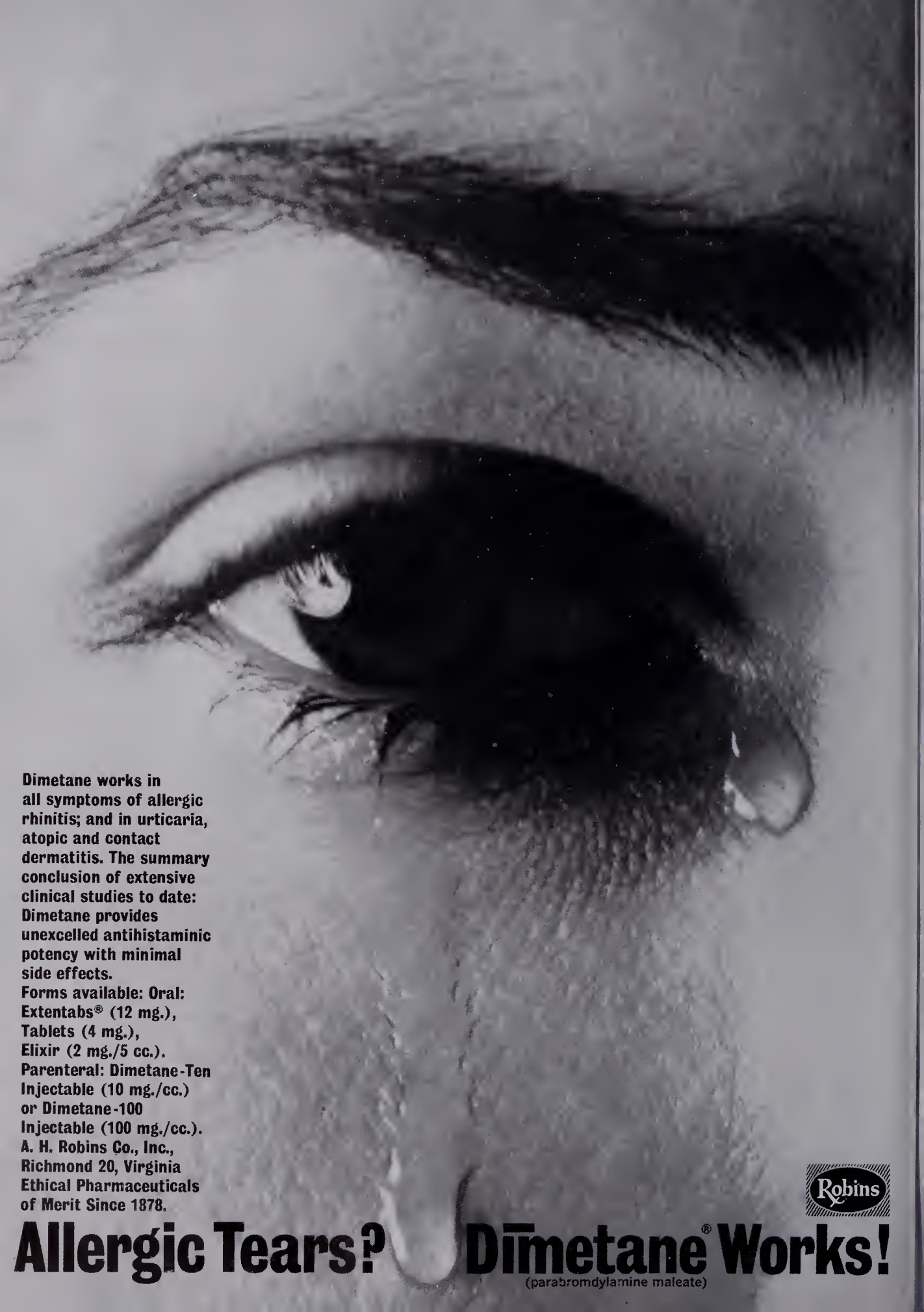
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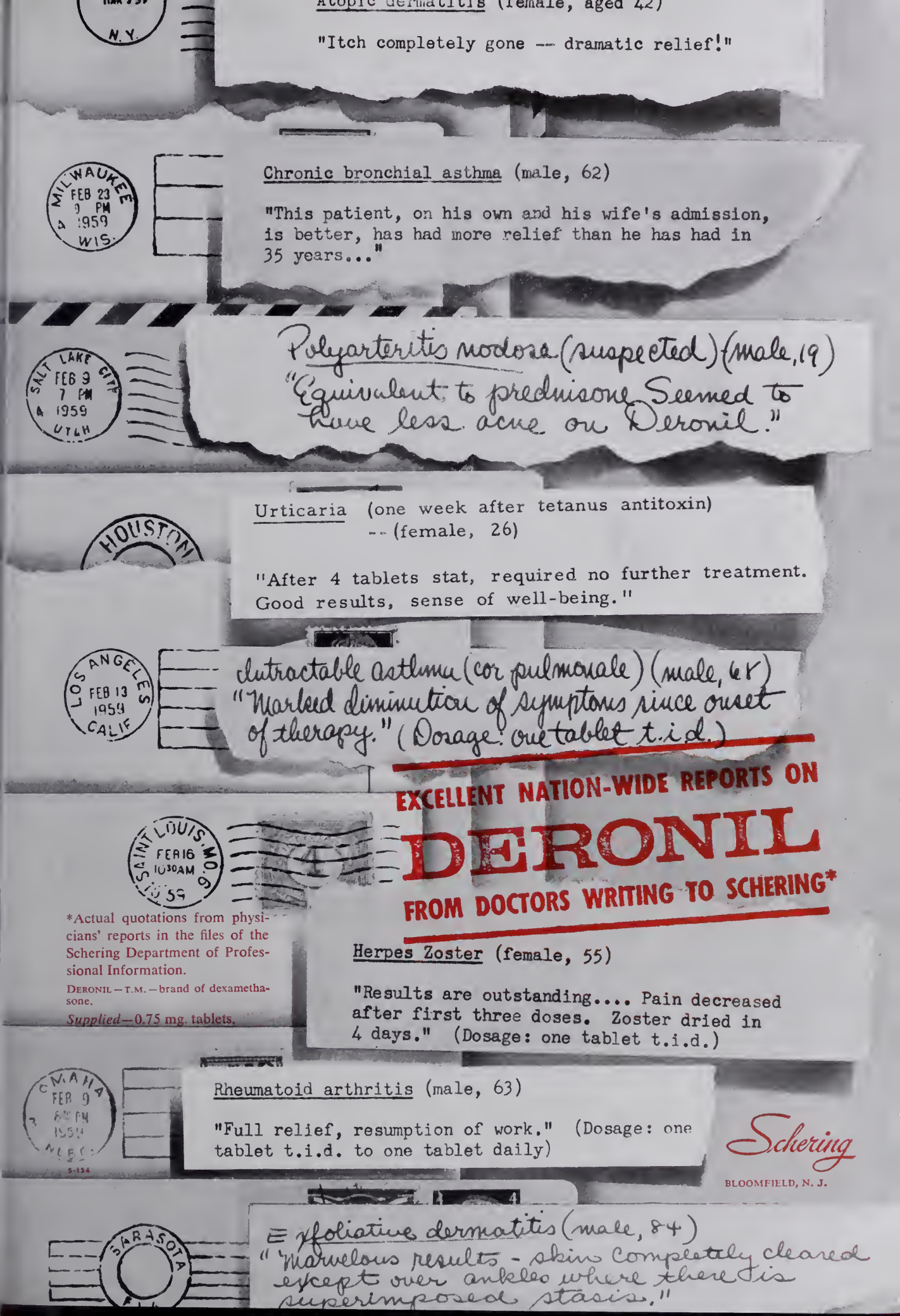
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Management Of Intestinal Obstruction, With A Review Of 178 Cases*

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WHEN there is interference with the normal progression of the contents of the intestinal tract,[1] intestinal obstruction occurs. This conception includes adynamic or paralytic ileus, but this paper will deal only with mechanical obstruction.

Causes

The greatest number of mechanical obstructions are caused by narrowing of the lumen due to strictures of the intestinal wall, obstruction of the lumen by a foreign body, pressure on the intestine from outside the intestinal wall, adhesions, hernias, volvulus, intussusception, embryologic defects (such as failure of rotation of the gut, Meckel's diverticula and openings in the mesentery or omentum), and interruption of the blood supply of the bowel as in embolus or thrombosis in the mesenteric blood vessels.

Strictures which obstruct the intestine may be acquired or they may be congenital in origin such as atresia of a segment of the small bowel and imperforate anus or rectum. New growths, either benign or malignant may result in strictures. Gall stone ileus and diverticulitis of the left colon are other examples of acquired strictures.

Adhesions and hernias are the most frequent causes of obstruction in this country, while in England and Australia intussusception is a more common cause. Although in Russia volvulus is one of the most frequent causes, it accounts for less than 10% of the obstruction in this country.

Types and Symptoms of Mechanical Obstruction

In simple obstruction there is only blockage of the normal progression of the intestinal current, while in strangulating obstruction there is the additional factor of interference with the blood supply of the bowel. The bowel above the obstructed point is distended, due to the accumulation of gas and liquids and the bowel below that point is collapsed. The distended intestine most proximal from the obstructed point contains most of the gas, while that closest to the obstruction contains most of the fluid. The progressive accumulation of gas and fluid within the lumen of the intestine causes distension; this is increased by swallowing of air, diffusion of gas from the blood stream into the intestinal lumen, multiplication of bacteria within the stagnant intestinal contents, and hypersecretion by the involved intestine. Hubbard and Wangensteen[9] have stated that about 68% of the gas in the intestine has its origin in swallowed air; 32% forms within the intestinal tract. In simple mechanical obstruction of the small intestine, there is progressive ac-

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cumulation within the lumen of unabsorbed secretions from the gastrointestinal tract above the site of obstruction. This may amount to as much as 8,000 c.c. in 24 hours. This fluid is normally secreted by the various digestive organs in one day's time. One thousand five hundred c.c. is bile, 700 c.c. is pancreatic juice, and 3,000 c.c. is succus entericus.

In strangulating obstruction there are, in addition to the distension, the signs of tissue death. The appearance of the wall of the gut may vary from a dusky cyanosis to a bluish black color. This discoloration is caused by interference with venous return from the intestine, which may eventually result in hemorrhagic infarction. In frank gangrene the lumen is filled with blood and there is a serosanginous fluid in the peritoneal cavity. After release of the obstructing mechanism, the viability of the bowel is indicated by the return of normal color, normal pulsations in the mesenteric vessels, and contractile responses to manipulation of the wall.

The first symptom of intestinal obstruction is pain. This is followed by vomiting and later by abdominal distension. The pain is intermittent and is most commonly described as a cramp, usually not long in duration. It reaches a peak of intensity which may last from a few seconds to three minutes and then quickly subsides. The cramp may return frequently or at longer intervals. When the small bowel is obstructed there is greater intensity of pain and there are shorter intervals between colicky attacks than in large bowel obstruction. When marked distension has occurred, the pain is usually less intense because the optimal contractile diameter of the bowel has been exceeded. When high-grade obstruction of the small intestine occurs, the vomiting is frequent and copious. This may not be true in obstruction of the colon. If the ileocolic valve is competent, there may be little vomiting, since the valve mechanism will permit gas and fluid to enter the colon without regurgitation back into the ileum. In this case there may be marked distension but little or no vomiting. Even when nausea is present, little vomitus is produced.

Physical Findings

Early in the course of obstruction there may be little to indicate that a serious condition is present. The pulse rate, respiration, temperature, and blood pressure are usually normal. Aside from the pain, the distension, and the vomiting, the patient may not appear particularly ill. Later in the course of the disease the patient appears acutely ill, with marked dehydration, an anxious expression, a feeble pulse, and cold clammy skin.

When the patient is first seen there is usually a certain amount of distension of the abdomen. The abdominal wall is soft and there is little or no localized tenderness unless strangulation is present. On auscultation of the abdomen there are bubbling, gurgling, tinkling noises, which increase in amount and intensity when a colicky pain occurs. If strangulation has occurred the abdomen may be relatively silent due to paralytic ileus secondary to the infarcted bowel. In this case there is a doughy feeling to the abdomen, with an indistinct mass occasionally palpable. There is also generalized tenderness without marked rigidity on palpation. These findings are due to bloody fluid which has escaped into the abdominal cavity and has caused peritoneal irritation. Visible peristalsis is seldom encountered in acute intestinal obstruction. In chronic or long-standing recurrent small bowel obstruction there may be a visible bowel pattern due to the hypertrophied muscle of the small bowel. This pattern is seen best in individuals with thin abdominal walls. The muscle hypertrophy which occurs in intermittent or chronic small bowel obstruction involves mainly the circular muscle of the intestinal wall.

Laboratory Aids in Diagnosis

Laboratory data are of little benefit in diagnosing bowel obstruction. There may be hemoconcentration, but this is a result of the obstruction and since it ocurs in many other conditions is not helpful in diagnosis. There may be a considerable shift to the left in the differential white blood count if infarction has occurred. "Scout" x-ray films of the abdomen are of great benefit because distension of the bowel is shown and one can usually tell by the bowel pattern whether the obstruction is in the small bowel or in the colon. There will be no gas evident in the intestine distal to the obstruction. If the obstruction is in the colon, one can usually estimate accurately the obstructed site. This is not applicable in small bowel obstruction. A film taken with the patient sitting or erect will show gas over fluid, since the gas

and fluid separate when stasis of the bowel contents occurs. In paralytic or neurogenic obstruction, gas and fluid level may be seen on the x-ray film, but in this case the distension involves the entire intestinal tract. Auscultation of the abdomen will usually indicate whether the obstruction is mechanical or paralytic.

Treatment

The treatment of mechanical obstruction is release of the obstructing mechanism, usually by operation. There may be many problems to be overcome before this treatment can take place. Each patient with intestinal obstruction must be treated individually and the optimum time for operation chosen. In general, the obstruction should be relieved as soon after the diagnosis is made as the condition of the patient permits. Measures for relieving distension should be started as soon as the true diagnosis is suspected.

A nasogastric tube with attached suction should be inserted as soon as one is available and before the patient is sent for x-ray studies. Blood for complete blood count and determination of carbon-dioxide combining power, chloride, sodium, potassium, and blood urea nitrogen values should be drawn immediately. Blood typing and cross matching is done immediately on admission to the hospital. Parenteral antibiotics should be given immediately for a reason which will be discussed later. A complete evaluation of the physical status of the patient should be made. In acute obstruction of short duration, delay of operation need only be as long as is necessary to complete this evaluation. In obstruction of longer duration, several hours may be necessary to at least partially bring the patient's hydration, depleted electrolytes, and restricted circulating blood volume to more nearly normal levels.

It has been our experience that, in the usual case, use of the short nasogastric tube such as the Levine tube is all that is necessary to control vomiting and retching and at least partially empty the distended upper gastrointestinal tract. Attempting to pass a long tube of the Miller-Abbot type may be a prolonged procedure. The manipulation of the patient and the tube incidental to getting the tube into the duodenum may use up a lot of the patient's already restricted reserve of strength. In addition, one is hampered in the institution of other supportive measures.

The long decompression tube is most useful when decompression of the bowel alone may relieve the obstruction. This is true, for example, in the obstruction which occurs in the immediate post-operative period due to inflammation or that which may occur with a ruptured appendix or acute pelvic inflammatory disease. In these cases, decompression with the long intestinal tube should be tried before operation is carried out. In the "closed loop" type of obstruction of the colon, use of the Levine tube would seem to be all that is necessary, because, as previously stated, about 70% of all gas in the intestine is swallowed air; the Levine tube will keep this air from reaching the colon. If the ileocolic valve is incompetent, the long tube may be helpful in relieving the distention of the small bowel.

The restoration of the circulating fluid volume of the blood and the correction of electrolyte disturbances is a subject in itself and cannot be included here. Appropriate amounts of fluid and the indicated electrolytes as determined by the laboratory data should be given the patient before, during, and after surgery. If depletion is severe, considerable time may be needed to effect restoration. It is time well spent and should not be cut short if one is sure that viability of the intestine is not being jeopardized by waiting a little longer.

In all cases of intestinal obstruction, antibiotic therapy should be instituted. Experimental and clinical experience has shown that both the morbidity and the mortality rates in intestinal obstruction are reduced by the use of antibiotics, which seem to reduce the toxic factor. The work of Hartwell and Hoguet[4] and of Gamble[5] and his associates has proved that there is no toxic absorption from the intestine unless strangulation has occurred.

In the presence of strangulation there is apparently increased permeability of the wall of the obstructed intestine as well as increased absorption. Recent investigations suggest that in the presence of strangulation and in the absence of perforation, the bowel wall may become permeable to lethal intestinal contents capable of producing peritonitis and that transperitoneal absorption of toxic substances into the circulation occurs. Laufman[7] and his coworkers have shown that segments of devascularized ileum, if relatively bacteria-free,

will undergo almost complete autolysis in the peritoneal cavity without apparent toxic effects. Cohn and Hawthorne[8] concluded from their studies that death in adequately treated experimental strangulation of the small bowel is due to the exotoxins of Clostridium welchii.

Many other toxic substances have been blamed, but the question of the origin and nature of the toxic factor in strangulated obstruction is still not settled. Experimental studies suggest that the bacteria within the contents of the lumen of a strangulated segment of intestine multiply rapidly, may contribute to the dissolution of the segment by invading the infarcted intestine, and destroy the bowel wall. These bacteria appear in the peritoneal exudate by transmural migration in the absence of gross perforation. Since sulfonamides and antibiotics are capable of reducing this bacterial flora, antibiotic therapy should be started as soon as the diagnosis of intestinal obstruction is made.

Management at Operation

Obstructions of the small bowel must be handled differently from obstructions of the large bowel, in which multiple procedures are frequently required before the continuity of the fecal stream is restored. Many large bowel obstructions are due to malignant lesions which will require definitive treatment at a later stage. Seldom is one justified in doing a primary resection and anastomosis of the colon for large bowel obstruction. Volvulus of the sigmoid colon may be relieved simply by rotating the bowel back to its original position. If volvulus has resulted in strangulation gangrene, a resection with a double-barrel colostomy may have to be done.

In nonstrangulated obstruction of the large bowel, a proximal decompression colostomy is probably the procedure of choice. Our best results with decompression followed colostomy at either the transverse or the sigmoid colon, depending on the level of the obstruction. Cecostomy is not as satisfactory as decompression done at a more distal point. The electrolyte and fluid requirements are a more pressing problem when the more proximal decompression is chosen. However, one must remember that if there is a continent ileo-cecal valve, there may be necrosis and rupture of the cecum or the adjacent ascending colon due to the great distension of this portion of the bowel. A loop colostomy in the transverse colon, with implantation of a mushroom catheter in the proximal limb of the colostomy, gives good immediate decompression of the proximal part of the colon and avoids the possibility of rupture of the cecum or ascending colon.

Obstructions of the right half of the colon are rare. When encountered they are usually due to a malignancy in the region of the hepatic flexure or the adjacent transverse colon. The best method of decompression is usually resection of the right colon with ileotransverse colostomy. This will relieve the obstruction as well as remove the obstructing lesion. Great care has to be taken to keep from rupturing the thin-walled cecum and ascending colon if considerable distension is present. Trocar decompression may be done to reduce this distension before resection is carried out.

In obstructions of the left half of the large intestine, a period of ten days to two weeks should be used to completely cleanse the proximal bowel so that the cause of the obstruction can be removed at a subsequent operation. At the subsequent operation an end-to-end anastomosis can usually be done between the two ends of the colon and, if desired, the colostomy can be closed. If closure of the previously made colostomy is not deemed desirable at the time of removal of the obstructing lesion, this may be done after complete healing of the anastomosis has taken place. Delayed closure of the colostomy decreases the chance of leakage at the site of the anastomosis.

Small bowel obstruction is in some ways simpler to manage at operation than large bowel obstruction, but at times the management may be more complicated. Also, considerable judgment may be needed to determine the best procedure in a given situation. Where simple obstruction due to an adhesive band is found, it may be necessary only to clip the adhesion. In simple obstruction due to external hernia, the release of the obstruction and repair of the hernia may be all that is necessary. However, frequently one may have to decide whether strangulation necrosis of the intestinal wall has occurred, making resection of the small bowel necessary. This can usually be determined simply by observing the appearance

of the intestine for five minutes after the obstruction has been released. If there is any question as to viability of the involved segment, resection should be done. The mortality rate from perforation of gangrenous small bowel approaches 100%. When resection of small bowel is necessary, an end-to-end anastomosis is the procedure of choice, since there is less chance of future complications with this type.

Intussusception is treated by reduction of the process, but resection is necessary when reduction is impossible. It is also required in intussusception of over 12 hours' duration, in which gangrene is a frequent finding, and for small bowel tumors, usually benign, which are a frequent cause of intussusception.

In primary small bowel obstruction due to adhesions, internal hernias, or other causes, the problem of distension may be very great. If obstruction has been present for some time, serious distension may be present in spite of decompression with the long or short nasogastric tube. Below the obstruction the bowel is collapsed. It is best to locate this collapsed intestine, which is usually found in the pelvis, and follow its course proximally until the obstructing point is found. If considerable distension is present, very little exposure is possible and there is great possibility of rupture of the bowel wall during manipulation. For these reasons, trocar decompression of the intestine should be done. This procedure as described by Barnes[3] makes operation much simpler, since one can easily visualize the cause of the obstruction and manipulation of the intestine is much less hazardous. Trocar decompression also allows the post-operative patient to be much more comfortable and there is much faster recovery of bowel tone. Another considerable advantage is the fact that one has no trouble closing the abdominal cavity after decompression has been carried out. When there is serious distension of the small intestine, trocar decompression should be the first thing done after opening the abdominal cavity.

In cases of recurrent small bowel obstruction or those in which considerable raw surface occurs during enterolysis, the Noble[2] plication procedure should be carried out after the release of the obstruction. This will prevent future recurrent small bowel obstruction in most instances.

The postoperative care of the patient relieved of intestinal obstruction is more or less a continuation of the preoperative care. Nasogastric decompression should be continued until gas has been passed either from an established colostomy or from the anus. When peristalsis is well established, the nasogastric tube can be removed and giving of liquids by mouth can be started. Administration of the appropriate intravenous or subcutaneous fluids and electrolytes is continued until oral intake is adequate. The tone of both skeletal and smooth muscle is greatly improved by the use of early ambulation in these patients, and fewer pulmonary and urinary complications occur. It is doubtful however, that the incidence of phlebothrombosis or thrombophlebitis with or without pulmonary embolus is reduced by early ambulation.

Review of Cases

During the period from July, 1947, to January, 1958, 178 cases of intestinal obstruction were observed by the surgical staff of the Lexington Clinic. Twenty-six of these involved large intestine and 152 involved small intestinal obstruction.

TABLE I
Colon Obstruction

Total Cases	26
Deaths	3—11.5%
Total Cases Operated On	25
Deaths	2—8.0%

In the 26 large bowel obstructions observed, (Table I) there were three deaths, two of which were postoperative. The third patient was an 88-year-old obese white male, who despite his moribund appearance on admission to the hospital, lived 26 hours. Autopsy revealed that he had a volvulus of the ascending colon with gangrene of the involved bowel. The other deaths occurred in a 71-year-old white male with a carcinoma of the sigmoid colon with distant metastases and in a 78-year-old white male with metastatic carcinoid obstructing the lower sigmoid colon.

Two of the three patients who had volvulus of the sigmoid colon were treated by resection and the other by unwinding the volvulus. Of the

ten patients with carcinoma of the left colon, nine recovered. Four patients had sliding inguinal hernia. Two of the obstructions in the large bowel were due to adhesions. There was one instance each of obstruction caused by carcinoma of the hepatic flexure, by ventral hernia, diverticulitis, anal stenosis, metastatic carcinoma of the cervix, metastatic carcinoid, and volvulus of the ascending colon. (Table II)

TABLE II
Colon Obstruction

Adenocarcinoma	11 cases
Sliding Inguinal Hernia	4 cases
Adhesions	2 cases
Ventral Hernia	1 case
Diverticulitis	1 case
Anal Stenosis	1 case
Metastatic Carcinoma of Cervix	1 case
Metastatic Carcinoid	1 case
Volvulus Ascending Colon	1 case
Volvulus of Sigmoid Colon	3 cases

In the 152 cases of small intestinal obstruction there were 12 hospital deaths, 11 of them postoperative. The other death was in a patient who was moribund on admission and was not operated on. Sixty of the 79 patients with obstruction from adhesions had had previous operations. (Table III) There were seven instances in which intussusception of the ileocolic type occurred. Five of them were in children, the youngest being 3 1/2 months old. The oldest of the two adults was 68. Two of the seven required small bowel resection.

There were five instances of internal hernia from congenital causes. One was due to a hiatus in the greater omentum and one was caused by herniation under the ligament of Trietz; two were a result of adhesions from a Meckel's diverticulum; there was one instance of herniation through the foramen of Winslow.

Twenty-five cases of small bowel obstruction were due to inguinal hernia, with six of them requiring resection. In the 16 instances of femoral hernia observed, the hernia occurred in 11 on the right side and on the left in five. Four of the 16 cases required resection of small bowel.

TABLE III
Small Bowel Obstruction

Adhesions	79-51.9%	Previously operated on 60-39.4%
Intussusception		7-4.6%
Congenital Internal Hernia		5-3.2%
Inguinal Hernia		25-16.3%
Femoral Hernia		16-10.5%
Gall Stones & Bezoar Ileus		5-3.2%
Postop Ventral Hernia		7-4.6%
Miscellaneous		15-9.8%

Note: 7 ventral hernia included in adhesions above.

There were four patients with obstruction from a gallstone in the small bowel, and in one the cause of obstruction was found to be a bezoar with a persimmon seed as its nidus. In seven cases of small bowel obstruction, postoperative ventral hernia was the cause. One of these patients died soon after admission without operation. She had had an incarcerated ventral hernia for ten days before being admitted to the hospital.

There were 15 cases of small intestinal obstruction due to miscellaneous causes, as follows: prolapse of the small bowel through the perineum after combined abdominoperineal resection of the rectum; volvulus of the small bowel; carcinoma of the gallbladder with extension; leiomyosarcoma, metastatic from the uterus; two cases of metastatic carcinoma from the sigmoid colon; metastatic carcinoma from the stomach; radiation stricture of the small bowel; metastatic carcinoma of the cervix; prolapse of a previously formed ileostomy; obstruction of a previously established ileostomy; obstruction of an ileocolostomy; carcinoma of the ovary with metastases; obstruction of the third portion of the duodenum due to the presence of markedly enlarged lymph nodes of undetermined cause; and stricture of the small bowel following incarcerated inguinal hernia.

Of 35 patients requiring resection of the small bowel, seven died, a mortality rate of 20%. (Table IV) The incidence of death in the 151 patients operated on was 7.3%. The actual causes of death of the 11 patients are interesting. Of six patients with ages ranging between 70 and 76, one died of pneumonia, one of carcinomatosis, two from pulmonary embolus, and one from peritonitis. This last pa-

TABLE IV
Small Bowel Obstruction

	Number	Deaths	Mortality
Total Cases Operated on	151	11	7.3%
Requiring Resection	35	7	20.0%
Not Associated With Malignancy	144	7	4.8%
Simple Obstruction	109	5	4.5%

tient also had a ruptured appendix as the cause of the small bowel obstruction. The cause of one death was not entirely clear, but it was thought to be due to coronary occlusion. One patient aged 40, died from peritonitis caused by leakage of contents of the gangrenous small bowel which had occurred before the patient had entered the hospital. The causes of death and the ages of the other patients were as follows: carcinomatosis (67 years old); extensive carcinoma of the liver, metastatic from the breast (45 years old); colitis (67 years old); and decompensated heart (85 years old).

In those patients with small bowel obstruction that was associated with carcinoma, there were seven deaths, a mortality rate of 4.8%. Nine of the 109 patients with simple small bowel obstruction not associated with bowel resection or malignancy died, a mortality rate of 4.5%. The reduction in mortality from 20% in those patients requiring resection to 4.5% in those patients not requiring resection, clearly shows the need for early operation, or at least operation before necrosis of the bowel wall has occurred.

In the entire series of 178 cases there were 176 operations with 13 deaths, a mortality rate of 7.3%. There were two deaths in 25 operations for large bowel obstruction, a mortality rate of 8%.

Excluding postoperative ventral hernias 76% of the obstructions due to adhesions had had previous operations. Twenty-seven per cent of the small bowel obstructions were caused by external hernia, 3.2% by internal hernias of the congenital type, and 3.2% by foreign bodies in the small bowel. Of the small bowel obstructions 4.6% were due to postoperative ventral hernias and 4.6% to intussusception. Miscellaneous causes accounted for 9.8%.

Summary

The diagnosis of intestinal obstruction depends on the history and especially the physical findings by palpation and auscultation of the abdomen. Confirmatory information of great aid is obtained on simple x-ray of the abdomen. There are few, if any, accurate signs of impending strangulation necrosis when intestinal obstruction is present. The mortality rate in intestinal obstruction remains high, principally due to associated disease and not to the intestinal obstruction itself. This rate is alarmingly increased when strangulation necrosis has occurred, which clearly points up the necessity of early diagnosis and treatment. Antibiotics should be used as part of the supportive treatment in cases of intestinal obstruction. More frequent use should be made of trocar decompression of the bowel since its immediate application to small bowel obstruction is extremely useful in preventing disaster at the time of operation and in cutting down on the morbidity in the postoperative period after the obstruction has been relieved. There is an increasing incidence of intestinal obstruction due to adhesions which apparently occur secondary to a previous operative procedure. This is due in large part to the increasing number of people who have been operated on. When nasogastric suction is unsuccessful in relieving intestinal obstruction, it should not be used for a prolonged period since there is increasing chance of loss of viability of the involved bowel with increasing passage of time. In a series of 178 patients seen at the Lexington Clinic, the mortality rate when resection of the bowel had to be done was about four times that in those cases not requiring resection.

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G. W. BAYLESS was the youngest child of Benjamin and Elizabeth Wood Bayless. He was born Jan. 17, 1817 at Washington in Mason County, Kentucky. He received a full grammar school and prep school education before entering Augusta College. He received an Academic degree from Augusta College.

George Wood Bayless then matriculated at the University of Louisville at the same time that Crawford Williamson Long matriculated at Transylvania College. After one year they both transferred to the University of Pennsylvania and were roommates. They graduated in the same class in 1839.

The University of Pennsylvania was first in renown among the twenty-eight medical schools in the country in 1838, and possessed the ablest faculty in the United States. Philip S. Physick, the pupil of John Hunter was Emeritus Professor of Surgery and Anatomy. He died during Bayless' first course. He was the first to use catgut as a ligature material. He devised the stomach tube and advised treatment of ununited fracture by the seton. William Gibson, the pupil of Sir Charles Bell, was the professor of Surgery. He was a friend of Lord Byron and was wounded by a stray bullet at the battle of Waterloo when he was there as a spectator. He was the first man to tie the common lliac artery (1812). He twice did a successful Caesarean section on the same patient. Nathaniel Chapman was professor of practice of physic and clinical medicine. His book on therapeutics was used as a textbook in many medical schools. George Wood taught Materia Medica. He, with Franklin Bache, edited the United States Dispensatory. William E. Horner was professor of Anatomy and discoverer of tensor tarsi (Horner's muscle). Hugh L. Hodge was professor of Midwifery. Hodge's forceps and pessaries were known all over the world. Robert Hare was the celebrated professor of Chemistry. When only 28 years of age he had invented the oxyhydrogen blowpipe.

Such were the men of the faculty of 1838-39. The session began November 1 and ended the first of the following March. The diploma of Georgium W. Bayles (later Bayless) was dated Aprilis quinton, Millesimo Octingentesimo et trigesimo none. The signatures of the professors are dimmed with age but the signatures of William Gibson, Nathaniel Chapman, Robert Hare and Franklin Bache are distinguishable with a magnifying glass and good lighting. The diploma is now in the possession of Mrs. S. Clay Lyon of Glenview. Agnew says that at this period this was the great clinical school of the country.

Saturday morning was a great time for lectures and clinics. Students attended the lectures of Samuel Jackson, Joseph Pancoast and William Gerhard. J. C. DaCosta speaks of Gerhard as America's greatest clinician. Clinics were held by John Rhea Barton, George Wood, William Norris and John K. Mitchell.

On Oct. 16, 1846 ether first was used in the East for narcosis by Dr. John Collins Warren. The name anesthesia was coined by Dr. Oliver Wendell Holmes, the champion of the infectiousness of puerperal fever, and a close friend of Dr. Joshua Barker Flint. Dr. Flint used ether 3 months later for anesthesia in the amputation of a lower limb in the presence of many colleagues. Dr. Flint was a great admirer and pupil of Warren and was notified by Dr. Warren of his success with ether. And thus came the early interest and use of this agent in Louisville. Dr. George Bayless began using ether for narcosis immediately after the success of Dr. Flint with it in Jan. 1847. Dr. Flint died in March, 1863. Shortly thereafter

*Presented before the Innominate Society, May 15, 1958.

the faculty of the medical department of the U. of L. convened at the office of Dr. George Wood Bayless for the purpose of expressing their sentiments toward a late colleague, Professor J. B. Flint.

In September 1857, Dr. Bayless was operating on a child under anesthesia and during the procedure the child died. Dr. Bayless and the anesthetic were blamed. Bitter and unpleasant words of criticism spread throughout the city and a complete investigation was demanded. Many thought that anesthesia was opposed to the plan of God according to the scriptures. Thus Dr. Bayless and a technique and agent were on trial. After bitterness, ignorance and agitation quieted, reason and understanding appeared. Anesthesia and Dr. Bayless were vindicated.

On Jan. 1, 1858 there appeared an article in the Louisville Democrat entitled *Pleasant Affair*. It went as follows—"The students of the University of Louisville, Medical Department, serenaded Dr. Bayless at his residence last night. The famous Louisville Silver Band discoursed the sweetest music. In response to loud calls, Dr. Bayless appeared and spoke as follows: 'Gentlemen: I feel profoundly grateful for this expression of affectionate regard on your part. It touches me deeply, I assure you. The occasion which has called forth this visit gives to it a value which could seldom, in the affairs of life, attach to any similar expression. When the current of life flows smoothly along it is very pleasant indeed to receive the flattering attentions of ones friends. But when a man becomes involved in trouble; when misrepresentation—I will not say malicious misrepresentation—but when through ignorance and passion, misrepresentation involves a man in serious difficulty, it is peculiarly gratifying to him to find his friends clustering around him. For he knows they are drawn to him by that beautiful chain of sympathy which links the finer parts of our nature together. And then again when he breasts the storm and rises triumphantly above it; when he comes out of the contest with no blot upon his escutcheon, with no tarnish upon his fair name, which he values more highly than wife and children, or life itself, then it is joyous indeed that his friends should welcome him.

" 'Gentlemen, I have referred to the occasion which has prompted this complimentary visit of yours. I lament it deeply, more deeply, I dare say, than any human being; not because of any consciousness of neglect of duty. No, so help me God, it is not. But I lament that in the dispensation of an allwise Providence that child should have died whilst I was honestly and earnestly doing all I could to relieve her from the disease she was laboring under; and died, too, when neither man's skill could have foreseen the danger nor averted it. I lament it, too, because of the alarm which it awakened in the public minds; and the fear which may often prevent persons from availing themselves of the benefits of Chloroform and Ether. Thus it will prove a public misfortune. But whilst this death will induce prudence and care on your part in the use of anesthetics, I beg you by no means to be deterred from their use.

" 'If I should have occasion to perform a painful surgical operation tomorrow, I would, without hesitation, give my patient the benefit of the great boon.

" 'But it is too cold this evening, Gentlemen, to go at length into this matter. Permit me to say to you that, after an old Kentucky custom, I cannot allow you to leave my house without breaking bread with me. It was an old Kentucky Custom to offer something to help the digestion of the bread. But you have heard my words of warning that I do not approve of placing the temptation of strong drink before young men. Therefore, whilst I will not offer you egg-nog nor apple-toddy, I most cordially invite you to come in and I will have some refreshments prepared for you.'

"The class accepted the cordial invitation of Professor Bayless, and in a short time a delicious collation was served by his accomplished daughters. After the class had fared sumptuously, Dr. Cowling was called upon and spoke as follows: 'Gentlemen: I hope no one will misunderstand the occasion of this gathering tonight. I hope no one will think it has any connection with the death of this poor girl. It would not enter his head to hint at such a thought, but that no more than 24 years ago, hundreds—perhaps thousands—believed that surgeons had so little care for human life as to sacrifice one through sheer neglect. Perhaps they may still think that we have meant to

make merry over the mischief we have done. No matter, we know better. For the poor girl we have regrets more sincere, perhaps, than many who have mourned so loudly. But for my part I am very glad that there was that excitement which followed the occasion. It brought about that full investigation which you saw yesterday—not indeed for yourselves, for you were witnesses of the scene, but for the many whose taste for the horrible had led them to believe that murder had been committed. It caused, I say, that investigation of the affair which led not only to the vindication of ourselves but our whole profession. In this matter you are equally interested with us. Had it been proven that by willful neglect this accident had happened, you might well have hesitated on the threshold of a profession in which men could become so callous as to be criminal. So we can rejoice together that it has been so thoroughly proved that we were not wanting in a single precaution to provide against what has happened.

But in the midst of all these happy thoughts, gentlemen, we cannot help but regretting not only that a life has been lost but that it goes on record against an agent which has prevented so much human suffering. Few indeed are the deaths that can be laid at its door, compared to the thousands of lives it has saved—to the pain it as assuaged—they sink into nothing. Let us hope that whatever dread this occurrence has caused will soon pass away and suffering humanity will not refuse the boon which is offered to it so freely.

I thank you for the regard you have shown me which I assure you is fully returned, and the friendship I have formed among you this winter will be impossible to efface.'

"Drs. Tibbs and Walling, in response to repeated requests made a few appropriate remarks."

While traveling across the plains to his farm in Missouri Dr. Bayless came upon a man frozen, deserted and neglected, having been left to the elements for an undetermined period of time.

Dr. Bayless placed him in his conveyance and took him to his farm home. There he treated his frostbites and rendered round the clock nursing. After a few days, it was evident that an amputation would be necessary. Dr. Bayless performed the amputation and kept the patient until he had made a complete recovery which was a total of six months.

He expected no remuneration for his kindness and compassion on this man who had been cast out by family and friends. The incident passed as just another happening and mission of mercy in the life of this outstanding physician and man of character. A few months later a beautiful hand wrought silver pitcher arrived from this grateful man as an expression of appreciation. The man was Vanderhorst of Charleston, S. C. The pitcher was an original Kirk with a high value and is still in the possession of the Bayless family.

Civic enterprises, too, commanded the attention of Dr. Bayless. The Cave Hill Cemetery Co. was formed by Legislative Charter in Feb. 1848 whereby L. L. Shreve, Dr. G. W. Bayless, Dr. Jedediah Cobb, Wm. B. Belknap, Dr. James C. Johnston and James Rudd and their successors were created a corporate body styled Cave Hill Cemetery Company. The City of Louisville, on June 1, 1848, conveyed 47 and 6/10 acres of its Cave Hill farm to these men to perpetually hold and use for a rural cemetery. The deed was coupled with some reservations of right of way and use of spring.

So great, however, was the objection of some of the original incorporators to the reservations in the deed of conveyance that the four first named resigned, and in accordance with the power then vested in them, the Mayor and Council elected in their stead John P. Morton, Dr. Joshua B. Flint, Thomas E. Wilson and Dr. T. S. Bell. On the 16th of June, 1848, the new board was organized with Dr. James C. Johnston, President; Dr. T. S. Bell, Secretary; and Thomas E. Wilson, Treasurer. The selection of the President was appropriate as he had been an advocate of the measure and the farm was his birthplace in 1795.

During the Civil War, Prof. Bayless was a sympathizer with the South and assisted the Cause of the Confederacy whenever possible. Confederate troops were instructed to see Dr. Bayless if they needed help in reaching their comrades through enemy lines. One lad misunderstood and called on Dr. Bailey instead of Dr. Bayless. Dr. Bailey then reported Dr. Bayless to the Union Forces. The Union General

ordered Dr. Bayless and his family to leave their home within 24 hours. Their home was on Fourth Street on the spot now occupied by the Rialto Theatre. All ten of them left and went to the home of Levin Lawrence Shreve, First President of the L & N Railroad, who lived on Chestnut Street. Dr. Bayless was ordered to Parris Island as a prisoner but at the time he was suffering with a very large carbuncle and thus his departure was postponed. Before he recovered, the war was over.

Dr. Bayless appreciated and enjoyed works of art. He watched for sales and attended them, choosing carefully the pieces that he wanted. After the death of George Keats, Louisville lumberman and brother of poet John Keats, a sale of his possessions was being held at his home on Walnut Street. Dr. Bayless was late in his arriving and he found that a painting of George Washington, that he had frequently admired, had been bought by a butcher in the West End. He sought out the butcher and bought it from him for $50.00. This portrait remained in the family and hung in the family home and the home of his son and of his granddaughter, Mrs. S. Clay Lyons, in Anchorage, Ky., for many years. It was not insured and no unusual value was placed upon it. A study of the painting proved it to be an original Gilbert Stuart and it brought a fabulous price a few years ago. Dr. Bayless was spending his time well when he was seeking out that West End butcher and he was investing wisely when he paid $50.00 for this portrait of George Washington.

During the 19th Century it was the custom for the Medical Schools to start their school year with an introductory address by an outstanding member of the faculty. Dr. Bayless delivered two such addresses, one in 1858 in the Kentucky School of Medicine and one in 1866 before the Medical Department of the University of Louisville.

Dr. Bayless modestly said, that he had "imperfectly sketched the history of distinguished men. The destinies of the school are now committed to our keeping." Then Dr. Bayless gave us a beautiful picture of his real self when he said, "The responsibility is a high one but the reward is correspondingly high. Are you prepared for the work and ready to meet the responsibility? I will speak for myself; and I feel free to answer for you. I pledge myself and you, here in the presence of these custodians of the Institution, of these citizens assembled here, and of these young men, who will be the living witnesses, to devote every talent and every energy I possess, to advance the highest interest of the school. And if we shall prove faithful to the trust committed to us, and the solemn pledge we have given, Louisville will have occasion to be proud of this noble institution of learning, which she so liberally endowed, when we shall have passed off from the stage, and some future historian shall be writing up its history yet to be enacted."

Faculty records of the University of Louisville Medical Department began with the year 1856. L. P. Yandell was Dean at that time. Meetings were held once a week during the school year. Candidates were interviewed, financial problems were discussed and methods of teaching were planned. J. W. Benson was Dean in 1857 and remained so through 1863. The name of George W. Bayless appears in the proceedings in his appointment to the chair of Physiology and Pathological Anatomy on June 20, 1863. Meetings were held in the office of one of the professors or dean. Dean Benson was arrested and thrown in jail on Nov. 24, 1863 and Prof. Bayless was chosen Dean, pro tempore. On Dec. 26, 1863 it was announced that Prof. Benson was still in prison but he was present at the Jan. 23, 1864 meeting.

Prof. Bayless remained Dean Pro-tem through April 1865. Prof. Benson was still under military arrest and Prof. Bayless was conducting his lectures. Prof. Bayless was elected Dean in April, 1865. Prof. Bayless was transferred to the anatomical chair at this time. Commencement exercises were held Feb. 2, 1866 and the record shows that Prof. Bayless was paid $680.00 for the school year which was approximately the same as Professors Bell, Holloway, Powell, Rogers and Smith received.

Prof. Bayless signed his name as Dean and Professor of Surgery on June 19, 1866. At this time the trustees were demanding the resignation of all Professors. Prof. Bayless was elected treasurer on Jan. 16, 1867 at which time J. W. Bodine was elected Dean. Prof. Bayless and Bodine were sent as delegates to the A.M.A.

Convention in 1867. Proceedings of the A.M.A. this year did not mention any activities of Prof. Bayless or Bodine.

Prof. Bayless was unanimously elected on May 26, 1869 to represent the faculty in convention of delegates from Western Colleges to assemble on tomorrow in the Library of this department. His instructions were to advocate low fees with an elevation of standard. At the June 7, 1869 meeting much time was given to the discussion of medical education and the standards. The possibility of a new medical school starting at the University of Kentucky was mentioned and frowned upon. Many thought that there was not sufficient clinical material in Lexington for teaching purposes.

Prof. Bayless and Bell stated that the school could be started only through Federal Legislation and Federal support. Prof. D. W. Yandell and Mr. Henry Watterson collaborated on a full history of the school as a supplement to the Courier-Journal on July 2, 1869. Shortly after this the health of Prof. Bayless began to fail and Dr. Cowling was asked to deliver some of his lectures.

Prof. Bayless remained active and attended faculty meetings regularly. On June 2, 1873 Prof. Bayless attended his last faculty meeting. He left the following day for Rock Castle Springs, Ky., hoping to regain health and strength during the summer months. The faculty met in the faculty room Sept. 10, 1873 and the Dean anounced the death of Prof. Bayless which occurred in Livingston, Ky., on the evening of Sept. 8, 1873. His wife, Virginia Lafayette Brown Bayless of Virginia, whom he had married Oct. 20, 1842 survived him. Eight children survived, there being 6 girls and two boys.

Manuscript Memos

Manuscripts should be submitted in duplicate to The Journal of KSMA, an original copy and one carbon, and typed with double spacing. Maximum length of an article should not exceed 4500 words, and the Board of Consultants on Scientific Articles prefers that they be briefer than this when possible.

Footnotes and bibliographies should conform to the style of the Quarterly Cumulative Index Medicus published by the American Medical Association. This requires in the order given: name of author, title of article, name of periodical, with volume, page, month—day of month if weekly—and year. The Journal of the KSMA does not assume responsibility for the accuracy of references used with scientific articles.

All scientific material appearing in The Journal is reviewed by the Board of Consultants on Scientific Articles. If illustrations are submitted with a paper, The Journal will assume the cost for the first three one-column width half tones. The cost of additional illustrations will be borne by the essayist.

Arrangements for reprints of an article should be made directly with the publisher of The Journal, Gibbs-Inman Printing Company, 817 W. Market St., Louisville, Ky.

The By-laws of the Kentucky State Medical Association provide that all scientific discussions and papers read before the KSMA Annual Meeting shall be referred to the KSMA Journal for consideration for publication. The by-laws further state that the editor or the associate editor may accept or reject these papers as it appears advisable and return them to the author if not considered suitable for publication.

Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville, Kentucky.

Recent Advances In Endocrinology*

James Robert Hendon, M.D.**

Louisville, Ky.

KNOWLEDGE of endocrine physiology and of the part the endocrine system furnishes in clinical disorders has progressed, in recent years, more rapidly than in any other area of medicine. The fundamental position of endocrine gland function in maintenance of homeostasis was pointed out notably by Cannon and Selye; the extensive implications of this concept are still in the process of exploration. It is possible to record here only a few indices of this healthy growth.

The Hypophysis

It has been gratifying to watch endocrinologic phenomena become part and parcel of physiological disciplines. It has been a little distressing to see the nucleus for all endocrine activity, so comfortably housed in the hypophysis, moved back still farther to the hypothalamus, and subject to cerebral and other influences. There is evidence that such ataraxic agents as promazine and chlorpromazine do affect pituitary hormonal activity and, through this medium, modify the functions of the adrenal cortices, the gonads, and probably other endocrine organs. In this general connection, it may also be worthy of note that the urine of patients treated with meprobamate contains a substance which may render determinations of 17 ketosteroid content valueless.

The ineffectiveness, in man, of administration of growth hormone derived from the pituitary glands of other animals has long been disappointing. Henneman and colleagues, Raben, and others have recently demonstrated growth increments in certain children following the use of extract from the hypophyses of human cadavers. Active study is under way to detect the responsible agent.

Increased incidence of hypophysectomy, and of brain surgery in general, has increased the incidence of diabetes insipidus, and hence our awareness of this clinical entity. Diabetes insipidus must always be considered to be a manifestation of a lesion of the hypothalamus, the infundibular stalk, or the neurohypophysis. Recently, I saw a patient in whom this diagnosis was established without a demonstrable lesion. Six months later autopsy disclosed a solitary metastasis to the hypothalamus from a small bronchiogenic carcinoma. The diagnosis of diabetes insipidus must be made with great care and with regard for the fact that obsessional water drinking, hyperparathyroidism, and even diabetes mellitus, can cause confusion. Opinion is still divided as to whether the best therapeutic agent is powdered posterior pituitary snuff or pitressin tannate in oil. More potent anti-diuretic preparations may be forthcoming.

The Thyroid

As yet, there is no one laboratory procedure which will provide an unquestionable diagnosis of thyroid disorder. Detailed history and painstaking physical examination retain their essential diagnostic role. Of the various laboratory aids the determination of serum protein bound iodine is the most valuable, providing it is known that none of the many factors which can influence serum iodine levels are acting, and providing that the test is carefully protected from any technical defect.

Surgery continues to be the most frequently employed therapy for hyperthyroidism. Radioiodine is being used successfully in increasing numbers of patients, particularly those above the age of forty with diffuse toxic goiters. Somewhat of a hindrance to this form of therapy is the difficulty of assessing accurately the dose of the radioisotope which will be required. Various elaborate formulas have been devised for

*Presented at the annual Postgraduate Medical Seminar Norton Memorial Infirmary, Dec. 18, 1958

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this purpose. They all amount to an educated guess.

The latent period of continucd thyrotoxic manifestations which must exist between the administration of radioactive iodine and the appearance of the euthyroid state can be made more comfortable for the patient by administration of an antithyroid drug such as propylthiouracil. More recently, reserpine and meprobamate have been shown to ameliorate the hyperthyroidal symptoms; the use of reserpine may be of value in thyrotoxic crises.

The concepts of hypometabolism without hypothroidism, and of hypothyroidism which does not respond to desiccated thyroid substance, have received quite a bit of publicity in the past year. Both are said to respond to triiodothyronine.

The first of thesc, hypometabolism without hypothyrodism. I do not comprehend at the present time; hence, I can neither defend nor oppose it. It seems fair to indicate that such a diagnosis should be made with the utmost care, lest we do a service to the drug houses and a disservice to our patients.

It seems to be true that hypothyroidism resistant to desiccated thyroid subtsance can occur. This is explainable if one postulates some failure at the cellular level which blocks breakdown of circulating thyroid hormone into effective compounds. Such cases are probably quite rare; the desired metabolic effect is achieved with triiodothyronine.

Hashimoto's chronic thyroiditis has always been a mysterious entity, from the etiological point of view. It now appears that this disorder occurs as a result of autoimmunization to circulating thyroglobulin. Thyroglobulin, not normally present in the blood stream, may reach the circulation after surgical or other trauma to the thyroid.

The Parathyroids

Increased awareness of the entity of hyperparathyroidism has resulted in the diagnosis and successful treatment of an increasing number of cases. Most of such cases in this country are suspected on the basis of urolithiasis, and Albright's sweeping dictum that every patient with urinary tract stone should be suspected of hyperparathyroidism is still a good one. However, hyperparathyroidism is being more frequently uncovered in the absence of bone disease or stone when such symptoms as vague abdominal pain, constipation, polyuria, peptic ulcer, pancreatitis, nausea, vomiting, lethargy and psychosis are investigated.

As yet, there is no one laboratory test which will positively indentify parathyroid hyperfunction. In addition to the better known findings of elevated serum calcium, decreased serum phosphorus, and hypercalciuria, studies of reabsorption of phosphorus by the renal tubules or the renal clearance of phosphorus have been advanced to strengthen the diagnostic armamentarium. These tests are not difficult; how reliable they will be is not yet certain. The unhappy fact that urinary tract infection can lead to renal deficiency which can produce alteration of parathyroid function does not grease the diagnostic skids. It is to be remembered too, that sarcoidosis, multiple myeloma, and other conditions can be mistaken for hyperparathyroidism, and vice versa.

The Adrenal Cortex

Adrenal cortical hormones such as cortisone and hydrocortisone, and their dehydrogenated analogues, prednisone and prednisolone, continue to be used in medicine with great frequency. It is doubtful if there is any disorder in which the so-called glucocorticoids have not been tried. In the competition for preference, new modifications of the steroid compounds are continually appearing, each said to be more potent in anti-inflammatory action and weaker in effect on electrolyte activity. It is neither possible nor profitable to compare these compounds here.

Even with the judicious use of the adrenal steroids, one sees untoward sequelae; one of the most dramatic of these is hemorrhage from peptic ulcer. It is probable that the compounds do not actually cause ulcer, but that by interfering with the usual phenomena of inflammation, they permit the development of complications in a preexisting lesion. In the treatment of hemorrhage or perforation, it is not wise to withdraw corticoid therapy.

We have been interested in the concomitant use of antibiotic and adrenal steroid therapy in severe infections. Our experience, and that of others, can be summarized briefly by this statement: Given an infectious process for which an effective antimicrobial agent is available, the combined effectiveness of this agent

and a glucocorticoid is superior to that of the antibiotic alone. Tuberculosis, once a contraindication for steroid usage, is now treated with these compounds plus antibacterial substances. The value of steroids in rheumatic heart disease and glomerulonephritis is quite debatable.

Interest in aldosterone, the adrenal cortical hormone with electrolyte effect par excellence, has been active since the presentation by Conn of a case of hyperaldosteronism. This entity is symptomatized by hypertension, weakness, recurrent paralysis, polydipsia, and polyuria and by the findings of alkalosis, hypernatremia and hypokalemia. The condition must be differentiated from chronic renal tubular acidosis. Hyperaldosteronism is nearly always the result of a benign adrenal tumor and the treatment is surgical.

Recently a case of suspected isolated hypoaldosteronism was reported.

Oral Hypoglycemic Agents

It is no longer news that blood sugar levels can be lowered in some cases of diabetes mellitus by the peroral use of sulfonylureas.. The presently available preparations are tolbutamide (Orinase®) and chlorpropamide (Diabinese®). Some differences exist in the clinical effectiveness of these compounds. Generally, however, they have shown to best advantage in the mild, stable, chronic hyperglycemia of middle age. "Brittle" or "labile" diabetes of the juvenile type is affected but little. The drugs are of no value in ketosis. In a patient previously controlled with either drug, exacerbations of diabetes occasioned by infection or other trauma will usually require the temporary use of insulin. The mechanism of action of the sulfonylureas is uncertain. They may stimulate the beta cells to secrete insulin, may inhibit the degradation of insulin, may inhibit the actions of glucagon.

A different type of oral hypoglycemic agent is under investigation. The active chemical grouping of these compounds is a biguanide. They are akin to Synthalin A which was found thirty years ago to have hypoglycemic properties and was rejected because of toxic effects. The compounds presently under study do not share this toxicity. Unlike the sulfonylureas, the hypoglycemic action of the biguanides occurs in the virtual absence of functioning islet cell tissue. In clinical use, some insulin is usually necessary or ketosis will develop.

In any case, it is probably worthwhile to remark that deficiency in carbohydrate metabolism may be only the most overt of several abnormalities at work in the syndrome of diabetes mellitus. Exclusive concentration on this facet of the disorder will not necessarily preclude the development of such complications as diabetic neuropathy, nephropathy, retinopathy or cardiovascular accidents, about which we know or can do little.

The Reproductive System

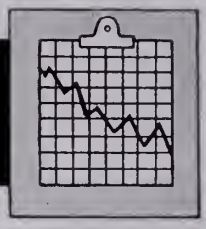
As concerns innovations in study of the reproductive system, we have been very interested in determinations of chromosomal sex as indicated by examination of cells of the buccal mucosa. This stemmed from the demonstration, by Moore and Barr in 1953, of a small chromatin mass in nuclei of cells removed by skin biopsy. Since this time, this chromatin mass has been found in virtually every tissue of the body and is most simply demonstrated, after proper staining, in scrapings from the mouth. It is seen as a tiny plano-convex body at the periphery of the nucleus. In chromosomal females, 50% to 80% of the cells studied show this sex chromatin; it is found in chromosomal males in 20%, or less, of the cells.

Use of this technique has shown a male pattern in cases of so-called Turners syndrome of ovarian agenesis which is associated with short stature, webbed neck, and other anomalies, and a female pattern in cases of Klinefelters syndrome of seminiferous tubule dysgenesis symptomatized by eunuchoidism, small testes, gynecomastia and aspermia. Such findings in these and other anomalies of the reproductive system have served to draw the distinction between sex determination, which is established at the time of impregnation, and sex differentiation, which can be modified by post-fertilization factors. Studies of chromosomal sex can be most valuable in newborns in which there is any doubt about maleness or femaleness.

One notable example of post-fertilization factors affecting sex differentiation is the appearance, at birth, of male type external genitalia in females whose mothers had received testosterone or progesterone during pregnancy.



CASE DISCUSSIONS
From The
University of Louisville Hospitals



LOUISVILLE GENERAL HOSPITAL*

Acute Hemorrhagic Pancreatitis With Delirium

History

JAMES E. ROSS, M.D., Senior Resident, Department of Surgery: A 68-year-old negro janitor, was admitted to the hospital as an emergency on September 22, 1958. His chief complaint was of generalized abdominal pain, constantly present, but intermittent in severity, both cramping and boring in nature, and the severity of which made him squirm. He was relatively more comfortable sitting with his knees drawn up. The pain was more pronounced in the upper abdomen than in the lower, and the constant boring pain was more pronounced in the periumbilical region. There was no radiation.

He arose at 6 a.m. on the day of admission, feeling well, and breakfasted on bacon and eggs. For lunch he had sauerkraut and one pint of wine. At 2 p.m. in rapid succession and in the following order, symptoms of nausea, repeated vomiting and abdominal pain appeared. Progression was rapid and he was admitted at 8 p.m.

He had repeatedly been drinking one pint of wine daily for three years. He drank no other alcoholic beverages. His past medical history, family history and review of systems revealed nothing of significance to the present illness.

Physical Findings

The patient was in moderate distress, squirming and seeking a position in which the pain would be less severe. Blood pressure was 170/80, pulse 76, respiration 28, temperature 99.2. The right pupil was irregular and did not react to light; the left was regular and reacted poorly to light. The abdomen was boardlike and generally tender, with moderate rebound tenderness. There were several superficial ulcers, each about 1 cm. in diameter, on the lateral aspect of the left upper arm. There were no pathological reflexes and no other physical findings of pathological nature.

Clinical Course

The blood seriology was negative, WBC 17,300; 88% polymorphonuclear leukocytes and 12% lymphocytes. The initial serum amylase was 445 Units, and the serum lipase was 110 Units. Liver function studies showed only a slight increase of serum bilirubin. Urinalysis revealed a 2 plus albumen and was otherwise not remarkable. X-rays of the abdomen were compatible with a moderate degree of paralytic ileus, and the chest x-ray revealed nothing abnormal. Treatment was instituted in accordance with a tentative diagnosis of acute pancreatitis. A Levin tube was inserted, Wangensteen's suction applied, and Demerol was given in small doses for pain.

On September 23, the patient's condition was much worse and laparotomy was done because of the possibility of a ruptured viscus. A considerable amount of blood-tinged peritoneal fluid was encountered, and the omentum and mesentery showed acute inflammatory changes. There was no evident perforated viscus. Examination of the pancreas revealed an area of necrosis 3 to 4 cm. in diameter which was hemorrhagic and dark in appearance. An amylase determination on the peritoneal fluid was 2,140 Units and the blood amylase on this same day was 560 Units.

An epidural catheter was inserted and repeated epidural blocks were initiated, using 1/2% xylocaine. On September 24, the patient began to perspire profusely and became disoriented as to time, place and person. He misidentified hospital personnel, was quite restless, and appeared frightened but apparently had no hallucinations. Amylase levels continued to

*Patient Protocol #263307

be elevated. Repeated tests for glucosuria remained negative. The blood pressure remained stable. Adequate calcium levels were maintained with calcium glutinate. Atropine was given in 1/150 Grain doses every six hours, and sedation was accomplished with Sparine and paraldehyde. Fluid and electrolyte balance was maintained with parenteral fluids containing therapeutic amounts of Vitamin B complex and C, and with added potassium chloride when indicated.

The delirium continued with occasional periods of violent and aggressive behavior, and on September 30, a wound dehiscence occurred and was repaired. Following this, the patient became lethargic and gradually regained orientation over the next 36 hours. By October 14, he was fully ambulatory and had no complaints. He was discharged on October 16, 1958.

Discussion

William J. Hockaday, M.D., Assistant Professor of Psychiatry and Associate in Surgery; This case could be discussed from a number of different standpoints, and should be, if space permitted and we intended to present a total picture of the theoretical and factual aspects. The discussion will be limited, however, to some observations gleaned from research and from the literature by those involved in the interdisciplinary psychiatry-surgery program at the University of Louisville School of Medicine.

Acute 'idiopathic' pancreatitis, whether associated with alcoholism or not, is frequently complicated by delirium. This case is illustrative of some of the problems in management which result from this complication. The incidence of toxic psychosis is probably at least 25%. Reports of the incidence in the literature vary considerably, and this may be due, in part, to the fact that mild toxic psychoses may manifest themselves only at night and thus be unrecognized. The etiology of these toxic psychoses is unknown. Some are undoubtedly delirium tremens occurring in conjunction with chronic alcoholism. The reported incidence of alcoholism in association with pancreatitis varies from 21%[1] to 73%[2] or more. Atropine intoxication is often blamed for toxic symptoms, but has played no significant role in our experience. Neither has liver damage, another one of the suggested causes. Although the mechanism of the toxic psychosis remains unclear, a clue has been offered in the form of a case report[3] describing cerebral demyelination in association with acute hemorrhagic pancreatitis. The author was able to produce identical lesions in animals by injection of pancreatic lipase.

We have done some preliminary studies on patients with recurrent eposides of acute pancreatitis. In such patients there frequently is a long history of psychological maladjustment, often with alcoholism. In evaluating the significance of reports concerning this, however, one must remember that a similar history can be obtained from most of the patients in many of the charity hospitals. There is no doubt, however, that anxiety, depression and narcotic addiction are prominent features in patients with recurrent pancreatitis, irrespective of the social and cultural factors. During the acute attack we have observed some very mild, but definite, pyramidal tract signs in several patients with toxic psychosis. At the same time there is apt to be a mild elevation of total protein in the spinal fluid. Three patients have been followed for a period of six months following their acute attack. In each of the three there were persistent and mild signs of organic brain damage on psychological testing, but this has not been clinically detectable. Although no conclusions are warranted, there does exist the definite possibility that there is some sort of chronic organic impairment in the central nervous system associated with recurrent episodes of acute pancreatitis.

The treatment of these toxic psychoses is apt to be more difficult than that of the patient with uncomplicated delirium tremens and chronic alcoholism. The reason for this is not only the existence of the pancreatitis. As exemplified in the case presented above, the delirium tends to be more persistent than that seen in the usual case of delirium tremens, and it tends to be equally severe both day and night. One of the less toxic phenothiazine derivatives may be used for around the clock control, thus avoiding the danger of continuous sedation with drugs such as paraldehyde.

Comment

Rudolf J. Noer, M.D., Professor and Chairman, Department of Surgery, University of Louisville School of Medicine: The delirium frequently associated with pancreatitis has received far too little study. It has rather glibly been dismissed in a high percentage of cases

as due to delirium tremens and/or atropine intoxication. Many of us are convinced that this delirium frequently is neither of these but rather a complication characteristic of the disease pancreatitis itself. It deserves and needs far more study. The Surgical Service of the University of Louisville is fortunate in having assigned to it a qualified psychiatrist who devotes a significant part of his time to a cooperative program of patient care, teaching and research on the Surgical Service. This has improved our functioning in these various areas with respect to many of the surgical diseases which we treat. We hope that clarification of the problem of delirium as a complication of pancreatitis will be one of the beneficial results coming from this inter-departmental cooperative study.

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1. Ivy, A. C., and Gibbs, G. E.: Pancreatitis: A Review, Surgery 31: 614, 1952.
2. Savage, C., Butcher, W., and Noble, D.: Psychological Manifestations in Pancreatic Disease. J. Clin. and Exper. Psychopathol, 13: 9, 1952.
3. Vogel, F. S.: Cerebrodemyelination and Focal Visceral Lesions in a Case of Acute Hemorrhagic Pancreatitis. A.M.A. Arch. Path., 52: 355, 1951.

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KSMA OFFICERS

1958

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1959



Robert W. Robertson, M.D.
President



Marvin Lucas, M.D.
Vice President—Central



T. O. Meredith, M.D.
Vice President—Eastern



Lillard F. Beasley
Vice President—Western

President-Elect

Irvin Abell, Jr., M.D., Louisville

Doctor Abell, who practices general surgery in Louisville, will be installed as President of the Kentucky State Medical Association on September 23 during the Association's Annual Meeting.

Born in Louisville on September 23, 1908, Doctor Abell is the son of the late Irvin Abell, Sr., M.D., who served as president of the KSMA in 1926 and later as AMA president. He attended Louisville Male High School and Philips Academy in Andover, Massachusetts. In 1931, he graduated from Yale University with a B. A. degree and in 1935 he received his M.D. degree from the University of Louisville School of Medicine. At the U of L he was in AOA honorary scholastic fraternity and Phi Chi Medical Fraternity. He took his surgical residency at Peter Bent Brigham Hospital in Boston in 1935-6.

Doctor Abell is currently on the staffs of St. Joseph Infirmary, Baptist Hospital, and Norton Memorial Infirmary. In 1954, he was president of the staff of St. Joseph Infirmary and in 1956, chairman of the Infirmary's executive committee.

From April, 1942 until December, 1945, Doctor Abell served in the U.S. Army Medical Corps, leaving the service with the rank of major. His tour of duty included service at the 30th Station Hospital in Teheran, Iran, and at Lawson, Billings, and Nichols general hospitals.

A past president of the Jefferson County Medical Society, he is currently chairman of the Society's Board of Governors. He is director and member of the executive committee of the Kentucky Division of the American Cancer Society and a member of numerous medical societies, including, American College of Surgeons, Southeastern Surgical Congress, Southern Surgical Association, Kentucky Surgical Society, the Innominate Society, and Transylvania.

Active in civic affairs, Doctor Abell is a director of the Louisville Chamber of Commerce and was recently named as one of a five-member professional committee to select Kentucky's 15 winners of The National Foundation's 1959 Health Scholarships. He serves on the Board of Overseers of both Nazareth and Bellarmine Colleges and is on the President's Civic Council of Bellarmine. A man of varied interests, his hobbies, include, gardening, farming (raises registered Hereford cattle), investments, swimming and boating.

When the House of Delegates selected him as the Association's president-elect at the 1958 meeting, it did so in the belief that his knowledge and insight, his experience and service, his high ideals and gentlemanly attitude, plus his leadership qualities would eminently equip him to fulfill the highest traditions of the office of KSMA president.

Vice Presidents

VICE PRESIDENT, CENTRAL

Marvin Lucas, M.D., Louisville

Doctor Lucas, a proctologist, graduated from the University of Louisville School of Medicine in 1936 and interned at General Hospital, Louisville. In 1958, he served the Jefferson County Medical Society as president. A diplomate of the American Board of General Surgery and the American Board of Proctology, Doctor Lucas was president of the Ohio Valley Proctological Society in 1956. He was president of the staff of St. Anthony's Hospital in 1952.

VICE PRESIDENT, EASTERN

Thomas O. Meredith, M.D., Harrodsburg

A native of Mercer county, Doctor Meredith graduated from the University of Louisville School of Medicine in 1933 and interned at Norton Memorial Infirmary, Louisville. He is now in general practice and surgery in Harrodsburg. From 1942-46, he was in the Army with the rank of major serving in the European Theater and North Africa. He is a member of the Board of Directors of Kentucky Physicians Mutual and is a past president of the Board of Kentucky Physicians Mutual.

VICE PRESIDENT, WESTERN

Lillard F. Beasley, M. D., Franklin

Doctor Beasley, who is in general practice and surgery in Franklin, is a graduate of the University of Tennessee College of Medicine in 1931. A native of Carthage, Tennessee, he took his postgraduate training at Memphis General Hospital, Hillman Hospital, Birmingham, Ala.; Baptist Hospital, Nashville; and Nashville General Hospital. Doctor Beasley was in the service from 1942-6 and attained the rank of Lt. Colonel. A Member of the Franklin Chamber of Commerce, he is also a Rotarian.



Louis Abell Jr.

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1959

KSMA Secretary and Treasurer

SECRETARY
Woodford B. Troutman, M.D., Louisville



Elected to his first five-year term as secretary in 1958, Doctor Troutman served as interim secretary from 1956-8 and was KSMA treasurer from 1946-58. A graduate of the University of Louisville School of Medicine in 1921, Doctor Troutman interned at McKeesport Hospital, Pennsylvania, and Bellevue Hospital in New York City. He practiced in Louisville for five years before studying abroad in Vienna, London, and Edinburgh. On his return in 1930, he began the practice of cardiology in Louisville. He is a Fellow of the American College of Physicians and is vice chairman of the Council on Allied Medical Services.

TREASURER
Delmas M. Clardy, M.D., Hopkinsville



A native of Tennessee, Doctor Clardy graduated from the University of Louisville School of Medicine in 1932 and is a general surgeon. He has been a member of the KSMA House of Delegates since 1936, except for four years of Army service during World War II. Doctor Clardy served as councilor for the Third District from 1950 to 1956 and has served on many KSMA committees. A past president of the Christian County Medical Society, he is now secretary of that society. He is a Fellow of the American College of Surgeons, a member of the Kentucky Surgical Society and the Southeastern Surgical Congress.

Officers of the KSMA House of Delegates

SPEAKER
Clyde C. Sparks, M.D., Ashland



President of the Association in 1955, Doctor Sparks became speaker at the close of the 1956 session. He was chairman of the KSMA Council in 1951-3. The son of a country doctor, graduated from the University of Louisville School of Medicine in 1932 and practiced in Fleming following two-years training at Louisville City Hospital (now General Hospital). He is a charter member and past president of the Kentucky Obstetrical and Gynecological Society and a Fellow of the American College of Surgeons. He has practiced general surgery and obstetrics and gynecology in Ashland since 1946.

VICE SPEAKER
George W. Pedigo, Jr., M.D., Louisville



Doctor Pedigo, who was elected vice speaker three years ago, is also associate editor of the Journal. A 1938 graduate of the University of Louisville School of Medicine, he is in private practice in Louisville as an internist. He is currently president-elect of the Jefferson County Medical Society and has also served the society as secretary and treasurer. A member of the American College of Physicians, Doctor Pedigo is also a diplomate of the American Board of Internal Medicine. (More details on Doctor Pedigo, who is also Associate Editor of the Journal of KSMA, are on the next page.)

AMA Delegates

DELEGATE TO THE AMA
W. Vinson Pierce, M.D., Covington



Named delegate in 1955 after serving as alternate delegate, Doctor Pierce graduated from the University of Louisville School of Medicine in 1934. He interned at St. Elizabeth Hospital in Covington and General Hospital in Louisville where he also took his residency training in urology. Doctor Pierce is a past president of the Kentucky Surgical Society, Kentucky Chapter, American College of Surgeons, and Kentucky Physicians Mutual, Inc. During World War II, he was a major in the medical corps.

DELEGATE TO THE AMA
Robert C. Long, M.D., Louisville



Doctor Long was appointed to fill the unexpired term of the late Clark Bailey, M.D., in December, 1957, and then was elected to his first full term in 1958. A graduate of the University of Louisville School of Medicine in 1940, he is a past president of the Louisville Obstetrical Society and has served the Jefferson County Medical Society in various capacities. He took his internship and part of residency training at Louisville General Hospital. Other residency training was taken at Chicago Lying-In Hospital.

KSMA Journal Editors

EDITOR
Sam A. Overstreet, M.D., Louisville



Doctor Overstreet, formerly scientific editorial editor, was named editor by the Council to succeed the late Guy Aud, M.D., on July 31, 1958. He was the Centennial president of the KSMA in 1950-51, president of the Jefferson County Medical Society in 1947, and is presently governor of the Kentucky Chapter, American College of Physicians. A graduate of the University of Louisville Medical School in 1923, he has long been active in medical affairs and is currently chairman of the Advisory Committee to Blue Cross.

ASSOCIATE EDITOR
George W. Pedigo, Jr., M.D., Louisville

The post of Associate Editor was created by the Council in July of 1958 and Doctor Pedigo was appointed to that position. Following his appointment he represented the Journal staff at the Regional State Medical Journal Conference in Austin, Tex. Among Doctor Pedigo's recent honors was his election to the Board of Directors of the Kentucky Chamber of Commerce. He is the first physician to serve in that capacity in the history of the State Chamber. He is currently president of the Kentucky Society of Internal Medicine.

(Dr. Pedigo's picture appears on the preceding page—since he is also vice speaker of the KSMA House of Delegates)

New Councilors

SEVENTH DISTRICT
Wyatt Norvell, M.D., New Castle

A former vice president (Eastern) of the KSMA, Doctor Norvell is also a past president of the Henry County Medical Society, a past director of the KAGP, and past chairman of the KSMA Rural Health Committee. Doctor Norvell graduated from the University of Louisville School of Medicine in 1941 and took his internship training in Texas at Scott and White Clinic and Gulf Coast and Santa Fe Hospital and at General Hospital, Louisville. He was in the USAF as a flight surgeon from 1942-6, leaving the service with the rank of major. He has been practicing in New Castle since 1946.

TENTH DISTRICT
Richard G. Elliott, M.D., Lexington

Doctor Elliott, a pediatrician, is a graduate of the Vanderbilt University School of Medicine in 1932. He did a rotating internship at Charity Hospital, New Orleans, and was assistant resident at Cincinnati Children's and Philadelphia Children's Hospital. In 1958, he was KSMA vice president (Eastern). A member of the American Board of Pediatrics, he has been practicing in Lexington since 1935 except for service as a major with the medical corps from 1941-5. A Rotarian, Doctor Elliott is active in civic affairs in Lexington and is a member of the American Academy of Pediatrics.

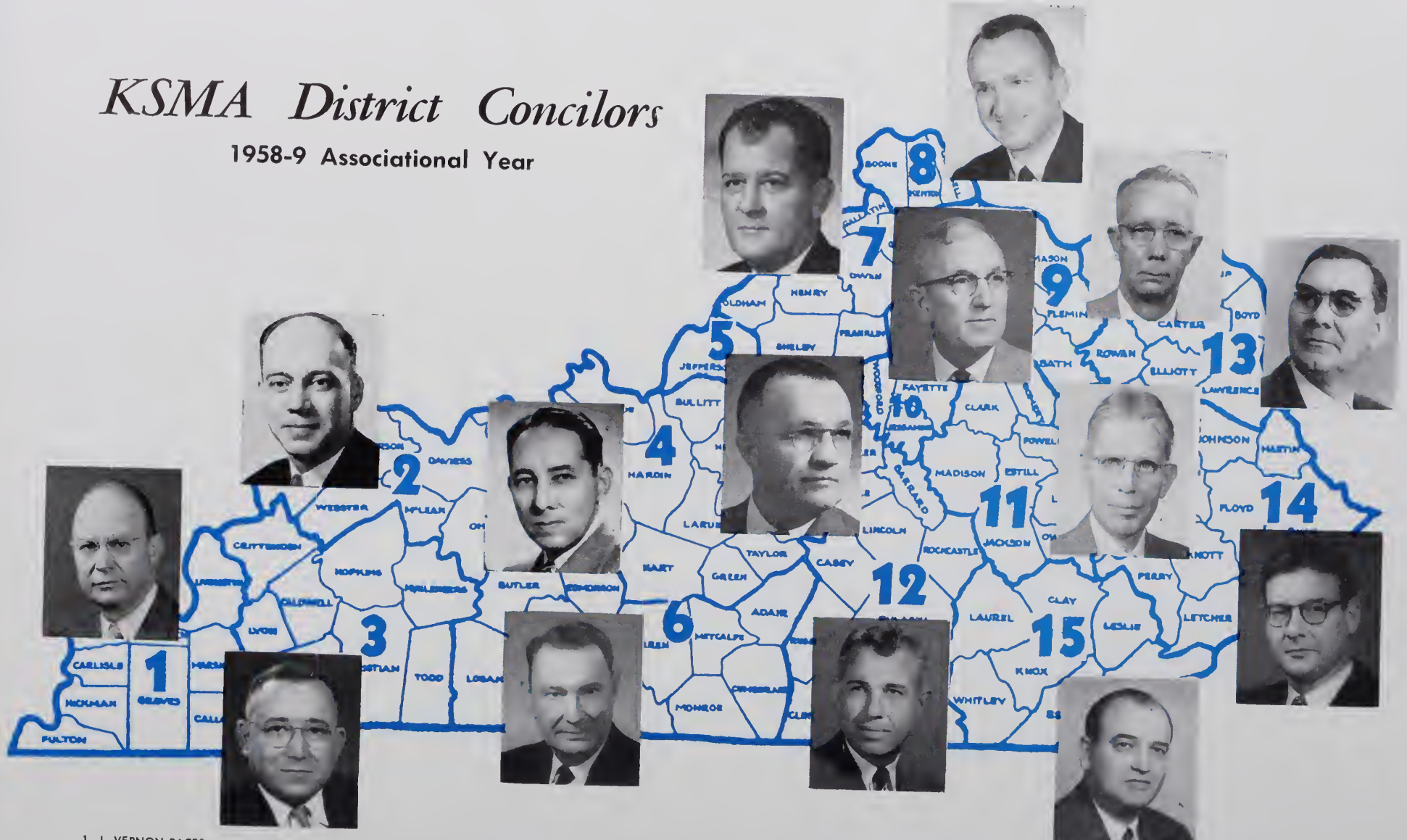
Election of Councilors

Five councilors will be elected by the House of Delegates following the election of general officers at its second meeting on Wednesday, September 23. Nominations for the five Districts will be made at a caucus of the delegates from each District immediately after the first session of the House on September 21. Each committee will report its nominees at the start of the second scientific session on Tuesday, September 22. Further nominations may be made from the floor. Councilors will be elected from the following districts: **1st District** (incumbent, J. Vernon Pace, M.D., Paducah); **3rd District** (incumbent, Ralph D. Lynn, M. D., Elkton); **4th District** (incumbent, the late W. Keith Crume, Bardstown); **12th District** (incumbent, Garnett J. Sweeney, M.D., Liberty); **14th District** (incumbent, Charles C. Rutledge, M.D., Hazard). Since the by-laws say that a councilor may only succeed himself once, the only incumbents eligible for re-election are Doctors Lynn (3rd) and Rutledge (14th). Biographical information on new councilors elected in 1958 appears above.

See map on next page →

KSMA District Concilors

1958-9 Associational Year



1. J. VERNON PACE* — Paducah
2. WALTER O'NAN — Henderson
3. RALPH D. LYNN — Elkton
4. W. KEITH CRUME — Bordstown *(deceased)*
5. CARLISLE MORSE* — Louisville
6. JOHN P. GLENN — Russellville
7. WYATT NORVEL — New Castle
8. NORMAN ADAIR* — Covington
9. J. M. STEVENSON — Brooksville
10. RICHARD G. ELLIOTT — Lexington
11. JOE M. BUSH — Mt. Sterling
12. GARNETT J. SWEENEY• — Liberty
13. CHARLES B. JOHNSON — Russell
14. CHARLES C. RUTLEDGE — Hazard
15. KEITH P. SMITH — Corbin

• *Chairman of Council*
* *Members of Exec. Committee*

KSMA Delegates

ADAIR
James C. Salato, Columbia

ALLEN
Owen L. Davis, Scottsville

ANDERSON
Boyd Caudill, Lawrenceburg

BALLARD
Jesse M. Hunt, Jr., Wickliffe

BARREN
W. H. Bryant, Glasgow

BATH

BELL
Chas. B. Stacy, Pineville
David Asher, Pineville

BOONE
G. L. Rouse, Florence

BOURBON
William Cox, Paris

BOYD
Wendell Lyons, Ashland
Phillip J. Winn, Ashland

BOYLE
Chris S. Jackson, Danville

BRACKEN
C. A. Marquardt, Augusta

BREATHITT

BRECKINRIDGE
W. R. Morris, Cloverport

BULLITT

BUTLER
D. G. Miller, Morgantown

CALDWELL

CALLOWAY
A. D. Butterworth, Murray

CAMPBELL-KENTON
Richard Rust, Newport
J. J. Rolf, Covington
W. R. Houston, Erlanger
R. J. Hoffman, Ft. Mitchell
Carl Kumpe, Covington
J. Humpert, So. Ft. Mitchell

CARLISLE

CARROLL
J. O. Mattox, Carrollton

CARTER
J. Watts Stovall, Grayson

CASEY
Lewis Wesley, Liberty

CHRISTIAN
Harvey B. Stone, Hopkinsville
Gabe A. Payne, Jr., Hopkinsville

CLARK
Earl B. Rynerson, Winchester

CLAY
W. E. Becknell, Manchester

CLINTON
E. A. Barnes, Albany

CRITTENDEN
R. M. Brandon, Marion

CUMBERLAND

DAVIESS
L. P. Moore, Owensboro
John S. Oldham, Owensboro
Hays Threlkel, Owensboro

EDMONSON

ELLIOTT
John F. Greene, Sandy Hook

ESTILL
R. R. Snowden, Ravenna

FAYETTE
C. C. Johnston, Lexington
N. L. Bosworth, Lexington
Robt. B. Warfield, Lexington
Robt. D. Shepard, Lexington
Carl H. Fortune, Lexington
Maurice Kaufmann, Lexington
D. E. Scott, Lexington
R. M. Slabaugh, Lexington

FLEMING
R. W. Fidler, Flemingsburg

FLOYD
Russell L. Hall, Wheelwright

FRANKLIN
John B. Clay, Frankfort

FULTON
Glynn F. Bushart, Fulton

GALLATIN
G. F. Harris, Warsaw

GARRARD
Paul Sides, Lancaster

GRANT
Lenore P. Chipman, Williamstown

GRAVES
W. B. Simpson, Mayfield

GRAYSON
P. A. O'Neill, Leitchfield

GREEN
Robert Shuffett, Greensburg

GREENUP
Billie Riddle, South Shore

HANCOCK

HARDIN
Ruel T. Routt, Sonora
Leo C. McCampbell, Elizabethtown

HARLAN
E. M. Howard, Harlan
P. J. Begley, Harlan

HARRISON
J. P. Wyles, Cynthiana

HART

HENDERSON

HENRY
W. P. McKee, Eminence

HICKMAN
V. A. Jackson, Clinton

HOPKINS
Loman Trover, Madisonville

JACKSON

JEFFERSON
L. Douglas Atherton, Louisville
McHenry S. Brewer, Louisville
W. Burford Davis, Louisville
Robert S. Dyer, Louisville
Robert Lich, Jr., Louisville
John J. Robbins, Louisville
L. H. Segerberg, Louisville
Samuel Weakley, Jr., Louisville
Carroll L. Witten, Louisville
Benjamin D. Boone, Louisville
J. Randolph Buskirk, Louisville
Rudy J. Ellis, Louisville
Thomas V. Gudex, Louisville
Robert L. McClendon, Louisville
Alfred O. Miller, Louisville
F. Albert Olash, Louisville
William E. Oldham, Louisville
Rudolph F. Vogt, Louisville
Everett H. Baker, Louisville
William Buschemeyer, Louisville
Kenneth P. Crawford, Louisville
Nathan I. Handelman, Louisville
Jack Hellman, Louisville
Daniel E. Mahaffey, Louisville
Henry Post, Louisville
Stanley T. Smith, Louisville
Robert S. Tillett, Louisville

JESSAMINE
J. S. Williams, Nicholasville

JOHNSON
James W. Archer, Paintsville

KNOTT
M. F. Kelley, Hindman

KNOX
H. L. Bushey, Barbourville

LARUE

J. D. Handley, Hodgenville

LAUREL
Boyce E. Jones, London

LAWRENCE
William J. McNabb, Louisa

LEE
J. M. Smith, Beattyville

LESLIE

LETCHER
Thurman M. Perry, Jenkins

LEWIS

LINCOLN
H. I. Frisbie, Stanford

LIVINGSTON

LOGAN
Carlisle V. Dodson, Russellville

LYON
J. E. Cotthoff, Kuttawa

McCRACKEN
Walt Johnson, Paducah
Walker Turner, Paducah
Leon Higdon, Paducah

McCREARY
H. A. Perry, Stearns

McLEAN
Samuel E. Scott, Livermore

MADISON
Hubert C. Jones, Berea
Douglas Jenkins, Richmond

MAGOFFIN

MARION
David Drye, Bradfordsville

MARSHALL
William J. Colburn, Calvert City

MARTIN

MASON
Harry C. Denham, Maysville

MEADE
George E. Clark, Brandenburg

MENIFEE
Donald L. Graves, Frenchburg

Delegates (continued)

MERCER
T. O. Meredith, Harrodsburg
METCALFE
E. S. Dunham, Edmonton
MONROE
James Carter, Tompkinsville
MONTGOMERY
William McKenna, Mt. Sterling
MORGAN
Alex Spencer, West Liberty
MUHLENBERG
G. L. Simpson, Greenville

NELSON
J. J. Sonne, Bardstown
NICHOLAS

OHIO
Oscar Allen, Beaver Dam
OLDHAM

OWEN
O. A. Cull, Owenton
OWSLEY
M. B. Gabbard, Booneville

PENDLETON
Robert L. McKenney, Falmouth
PERRY
C. H. Williams, Hazard
PIKE
W. C. Hambley, Pikeville
POWELL
Sam Scrivner, Stanton
PULASKI
B. L. Ramsey, Somerset

ROBERTSON
Perry Overby, Mt. Olivet
ROCKCASTLE
Robert E. Arnold, Mt. Vernon
ROWAN

RUSSELL

SCOTT
C. R. Lewis, Georgetown
SHELBY
Donald Chatham, Shelbyville
SIMPSON
L. F. Beasley, Franklin
SPENCER
M. H. Skaggs, Taylorsville

TAYLOR
H. F. Chambers, Campbellsville
TODD
Robert A. Clary, Guthrie
TRIGG
John Futrell, Cadiz
TRIMBLE
Carl Cooper, Bedford

UNION

WARREN
Harold Keen, Bowling Green
WASHINGTON
R. A. Hamilton, Springfield
WAYNE
R. B. Breeding, Monticello
WEBSTER

WHITLEY
W. M. Buttermore, Corbin
WOLFE
Milton O. Beebe, Jr., Hazel Green
WOODFORD
F. D. Willey, Versailles

House to Elect KSMA Officers for 1958-9 on Sept. 23

Officers of the KSMA to be elected for 1959-60 by the House of Delegates at its second session on September 23 are:

President-Elect: (Eastern) one year
Vice Presidents: (Central) one year
(Eastern) one year
(Western) one year
Delegate to the AMA: (W. Vinson Pierce, Covington, incumbent) two years
Alternate Delegate to the AMA; (Foster D. Coleman, Louisville, incumbent) two years

Candidates will be announced by the nominating committee at the beginning of the second scientific session on Tuesday, September 22. Voting on these nominations and further nominations made from the floor without discussion, will take place at the second session of the House on Wednesday, September 23.

1959 Annual Meeting Tribute to KSMA's 21st President



The 1959 KSMA Annual Session has been designated the J. L. Dismukes Memorial Meeting in honor of the Association's twenty-first president. J. L. Dismukes served as president in 1878. A biographical sketch on Doctor Dismukes, prepared by Emmet F. Horine, M.D., Brooks, will appear in the program booklet. Last year's meeting honored L. P. Yandell, M.D., KSMA's 20th president.

Emergency Call Information Listed

If you want to be contacted in case of emergency during the Annual Meeting, give your secretary the numbers listed below.

The number to call during the scientific sessions at the Columbia Auditorium from 9 to 5 daily is **JUniper 3-1933.** During the House of Delegates meetings in the Roof Garden of Brown Hotel on Monday, September 21, and Wednesday, September 23, the number to call will be **JUniper 4-1311 Extension 92.**

Nominating Committee to Convene Following 1st House Session

The nominating committee will meet on Monday, September 21, following the close of the First Session of the House of Delegates. At this time, members wishing to confer with the committee regarding the 1959-60 general KSMA officers will have an opportunity to do so.

The committee will report to the House of Delegates just before the close of the House's final session on Wednesday, September 23. At this time, nominations may be made from the floor "without discussion or comment."

Included in the nominating committee are: James W. Archer, M.D., Paintsville, chairman; Joe M. Bush, M.D., Mt. Sterling; Wendell V. Lyon, M.D., Ashland; J. B. Marshall, M.D., Louisville; and Gaithel L. Simpson, M.D., Greenville.

Reference Committee Activity

At the first meeting of the House on September 21, all officer, committee reports and resolutions will be referred to one of seven reference committees by Speaker Clyde C. Sparks, M.D., Ashland. Reference committees will meet at 2 p.m. on Tuesday, September 22, at the Columbia Auditorium. Members of the committees will assemble at 1:45 for short briefing sessions before the seven Reference Committees go into session. **Any member of the Association wishing to testify on any resolution is urged to be present at 2 p.m.** Open hearings for each reference committee will last at least an hour in order that all who wish to speak may be heard. Following the open hearings, the Committees will go into executive session to restudy the reports and review the testimony given at the hearings. Recommendations will be made for presentation at the final sessions of the House of Delegates Roof Garden at the Brown Hotel on Wednesday night, September 23. Following are the reference committees appointed by Doctor Sparks to serve during the 1959 session:

Reference Committee Appointments

REFERENCE COMMITTEE NO. 1

Reports of Officers and Councilors

Rudolph F. Vogt, Louisville, Chairman
Loman C. Trover, Madisonville, Vice Chairman
W. Burford Davis, Louisville
Boyce E. Jones, London
James S. Williams, Nicholasville

REFERENCE COMMITTEE NO. 2

Reports on Medical Care, Medical Education, Hospitals and Related Subjects

W. C. Hambley, Pikeville, Chairman
Robert S. Tillett, Louisville, Vice Chairman
Gladys L. Rouse, Florence
Alex Spencer, West Liberty
C. R. Lewis, Georgetown

REFERENCE COMMITTEE NO. 3

Reports on Legislation and Public Relations

John T. Giannini, Louisville, Chairman
Henry F. Chambers, Jr., Campbellsville, Vice Chairman
John F. Greene, Sandy Hook
Paul J. Sides, Lancaster
Russell L. Hall, Wheelwright

REFERENCE COMMITTEE No. 4

Reports on Miscellaneous Business

Robert S. Dyer, Louisville, Chairman
Richard J. Rust, Newport, Vice Chairman
Robert W. Fidler, Flemingsburg
Donald Chatham, Shelbyville
Leo C. McCampbell, Elizabethtown

REFERENCE COMMITTEE No. 5

Reports on Miscellaneous Business

O. Leon Higdon, Paducah
W. P. McKee, Eminence, Vice Chairman
L. H. Segerberg, Louisville
Wilbur R. Houston, Erlanger
George E. Clark, Brandenburg

REFERENCE COMMITTEE NO. 6

Reports on Miscellaneous Business

N. L. Bosworth, Lexington, Chairman
Douglas H. Jenkins, Richmond, Vice Chairman
Harold Keen, Bowling Green
Billy J. Riddle, South Shore
W. H. Bryant, Glasgow

REFERENCE COMMITTEE NO. 7

Reports on Miscellaneous Business

Carl Cooper, Bedford, Chairman
L. Douglas Atherton, Louisville, Vice Chairman
Maurice Kaufmann, Lexington
John P. Wyles, Cynthiana
V. A. Jackson, Clinton

CREDENTIALS COMMITTEE

Robert L. Shuffett, Greensburg, Chairman
David Drye, Bradfordsville, Vice Chairman
Martin H. Skaggs, Taylorsville

ALTERNATES

John J. Rolf, Covington
Robert B. Warfield, Lexington
Hubert G. Jones, Berea
William H. McKenna, Mt. Sterling
Robert L. McClendon, Louisville
Patrick A. O'Neill, Leitchfield
Owen L. Davis, Scottsville
William McNabb, Louisa
McHenry S. Brewer, Louisville
Richard M. Brandon, Marion
Willard M. Buttermore, Corbin
Walter R. Morris, Cloverport

Annual Session Highlights



Columbia Auditorium
Louisville
Sept. 22 - 24

The Columbia Auditorium, 824 South Fourth Street, is the site of the Scientific Session and the Scientific and Technical Exhibits.

• **SCIENTIFIC SESSIONS** will be held at the Columbia Auditorium, Louisville, daily on September 22-23-24. Outstanding scientific presentations, two panel discussions, and a Clinicopathologic Conference will be highlights of the sessions which will feature 22 noted speakers. Panels on "Biliary Tract Disease" on Monday at 10:30 and on "Reversible Renal Failure" at 3:30 on Thursday will have top flight participants.

• **THE HOUSE OF DELEGATES,** policy making body of the Association, will hold two meetings during the Annual Session. First meeting of the House will be on Monday, September 21, and the second session on Wednesday, September 23. Both sessions will be in the Roof Garden of the Brown Hotel and will come to order at 7 p. m., following registration at 5:30 p. m. and a subscription dinner at 6 p. m. Officers for 1959-60 will be elected at the House's second session.

• **TWELVE SPECIALTY GROUPS** will hold their meetings in conjunction with the Annual Session. Meetings will be held either from 2 p. m. to 4:30 p. m. on Tuesday, September 23, or Thursday, September 24 from 9 a. m. to 11:50 a.m. KSMA members are welcome to attend any of these meetings.

• **PRESIDENT'S LUNCHEON** will have as its featured speaker Frank Brown Berry, M.D., Washington, D. C., Assistant Secretary of Defense, Health and Medical, who will talk on his experiences in that office. Another feature of the meeting will be presentation of the KSMA's three top awards.

• **A LUNCHEON FOR NEW MEMBERS,** an innovation this year, will honor all physicians who have become members of the Association since September 1, 1950. The luncheon is scheduled for Tuesday noon, September 22, in the Louis XVI Room of the Brown Hotel. New members have been issued invitations to attend.

• **UNIVERSITY OF LOUISVILLE MEDICAL SCHOOL ALUMNI REUNIONS,** a traditional adjunct to the meeting, will be held again this year. Annual alumni dinner will take place in the Crystal Ballroom of the Brown Hotel on Thursday, September 24. Ten classes will be holding reunions this year, including all five year classes from the class of 1909 to 1954.

Official Call

KSMA Annual Meeting

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the KSMA will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday, and Thursday, September 22, 23, and 24, 1959. The General Session will be called to order at 9 a.m. Tuesday.

The House of Delegates

The first regular session of the House of Delegates will convene at 7 p.m., Monday, September 21; the second regular session will begin at 7 p.m., Wednesday, September 23. Both sessions will be held in the Roof Garden of the Brown Hotel.

Registration

The registration department will be open in the Roof Garden of the Brown Hotel from 5:30 p.m. to 8 p.m., on Monday, September 21, and Wednesday, September 23. It will be open in the Columbia Auditorium from 8 a.m. to 5 p.m. on Tuesday, September 22; Wednesday, September 23; and Thursday, September 24.

Annual Meeting
Woman's Auxiliary to the KSMA

Tuesday, September 22

Pre-convention Board Breakfast, 8:45 a.m., Parlors A, B, and C, Brown Hotel; Formal Opening of the 37th Annual Meeting, 10:30 a.m. South Room, Brown Hotel. Subscription Luncheon, South Room, Brown Hotel 12:30 p.m. Tea honoring Distinguished guests, Louis XVI Room, Brown Hotel, 3:30 p.m.

Wednesday, September 23

Final Business Session, 9:00 a.m., South Room, Brown Hotel. Subscription Luncheon—Travel Fashion Show, 1:00 p.m., Mason Dixon Ball Room, Freedom Hall, Fairgrounds.

Thursday, September 24

Post-convention Board Meeting and Subscription Breakfast, 9:00 a.m., South Room, Brown Hotel. Buses leave Brown Hotel for tour and Luncheon at General Electric Company and tour of Farmington Museum, 11:40 a.m.

Asst. Sec. of Defense to Speak at President's Luncheon

The Assistant Secretary of Defense (Health and Medical), Frank Brown Berry, M.D., will be the featured speaker at the President's Luncheon during the KSMA Annual Meeting on Wednesday, September 23, according to Robert W. Robertson, M.D., KSMA President, Paducah, who will preside.



Doctor Berry, a 1909 graduate of Harvard Medical School, will speak on some of his activities in the office of Assistant Secretary of Defense (Health and Medical). He served in the medical corps in both world wars and is presently a Brigadier General (retired) in the Reserve. He was in private practice as a surgeon in New York from 1924-54. From 1946-54 he directed the first surgical and chest division of Bellevue Hospital, New York.

Another highlight of the President's Luncheon will be presentation of the three KSMA awards—Distinguished Service Award, Outstanding General Practitioner Award, and the R. Haynes Barr Award—by KSMA Secretary Woodford B. Troutman, M.D., Louisville.

Awards Presentations Scheduled During President's Luncheon

Presentation of Awards will take place at the KSMA President's Luncheon in the Ballroom of the Brown Hotel on Wednesday, September 23.

Recipients of the three KSMA Awards — *Distinguished Service Medal, the Outstanding General Practitioner Award, and the R. Haynes Barr Award*— will be chosen by the Awards Committee. Last year's recipients were: Brent Weddle, M.D., Somerset, outstanding GP; Joseph E. Johnson, M.D., South Williamson, Distinguished Service Award; and the late James F. Blackerby, Louisville, the R. Haynes Barr Award for outstanding contributions by a layman in the field of public health.

Awards presentations will be made by KSMA secretary Woodford B. Troutman, M.D., Louisville. Members of the Awards Committee are: Glenn U. Dorroh, M.D., Lexington, chairman; William H. Bizot, M.D., Louisville; Donald Chatham, M.D., Shelbyville; Robert W. Fidler, M.D., Flemingsburg; and Maher Speevack, M.D., Munfordville.

While attending the KSMA Annual Meeting all members and guests are urged to wear their badges at all times.

1959 Annual Meeting Program Summary

The Kentucky State Medical Association

September 21, 22, 23, and 24

Louisville

MONDAY, SEPTEMBER 21

12:30 noon	Council Meeting	Louis XVI Room, Brown Hotel
5:30 p. m.	Registration, House of Deleagtes	Roof Garden, Brown Hotel
6:00 p. m.	Subscription Dinner—House of Delegates	Roof Garden, Brown Hotel
7:00 p. m.	First Meeting of House of Delegates	Roof Garden, Brown Hotel

TUESDAY, SEPTEMBER 22

8:00 a. m.	Registration	Columbia Auditorium
8:45 a. m.	Opening Ceremonies	Columbia Auditorium
9:00 a. m.	First Scientific Session Scientific Papers, 9:00 to 9:40 Panel Discussion, 10:30 to 11:50	Columbia Auditorium
9:40 a. m.	President's Address	Columbia Auditorium
12:00 noon	Annual Luncheon for New Members	Louis XVI Room, Brown Hotel
2:00 p. m.	Specialty Group Sessions (6 specialty groups will meet simultaneously. Any KSMA member may attend any of these meetings. See pages 948-949 in program)	
	Reference Committee Meetings	Columbia Auditorium

WEDNESDAY, SEPTEMBER 23

9:00 a. m.	Second Scientific Session Scientific Papers, 9:00 to 10:00 Clinicopathological Conference, 10:30 to 11:10	Columbia Auditorium
11:50 a. m.	President's Luncheon for Distinguished Guests	Ballroom, Brown Hotel
2:00 p. m.	Third Scientific Session Scientific Papers, 2:00 to 4:30 Motion Picture, 4:40	Columbia Auditorium
5:00 p. m.	Council Dinner	Louis XVI Room, Brown Hotel
5:30 p. m.	Registration, House of Delegates	Roof Garden, Brown Hotel
6:00 p. m.	Subscription Dinner, House of Delegates	Roof Garden, Brown Hotel
7:00 p. m.	Second Meeting, House of Delegates	Roof Garden, Brown Hotel

THURSDAY, SEPTEMBER 24

9:00 a. m.	Specialty Group Sessions (Six specialty group programs will be held simultaneously. Any KSMA member may attend any of these meetings. See pages 951-952 in program)	
12:00 noon	Council Luncheon	Parlors A, B, C, Brown Hotel
2:00 p. m.	Fourth Scientific Session Scientific Papers, 2:00 to 3:00 Panel Discussion, 3:30 to 4:30	Columbia Auditorium
5:00 p. m.	Adjournment	

A 30-minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

(Full Scientific Program starts on page 948)

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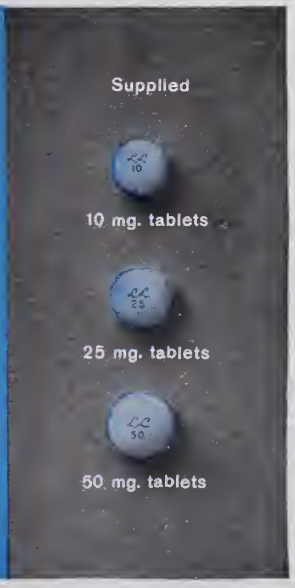
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SCIENTIFIC PROGRAM

J. L. Dismukes Memorial Meeting

The Kentucky State Medical Association

Columbia Auditorium, Louisville

TUESDAY, SEPTEMBER 22

COLUMBIA AUDITORIUM

Registration

8:45 **Opening of General Session**
Call to Order by the President
Robert W. Robertson, M.D., Paducah
Invocation
Right Reverend Monsignor Alfred F. Horrigan, PhD., President of Bellarmine College
Welcoming Remarks
Foster D. Coleman, M.D., Louisville, President, Jefferson County Medical Society

FIRST SCIENTIFIC SESSION

COLUMBIA AUDITORIUM
9:00 A.M.

Robert W. Robertson, M.D., KSMA President, Presiding

SCIENTIFIC PAPERS

9:00 **"Treatment of Arthritis of the Hand"**
S. Benjamin Fowler, M.D., Nashville, Tenn.

9:20 **"Thoracic Emergencies in Infancy and Childhood"**
Herbert Sloan, M.D., Ann Arbor, Mich.

9:40 **President's Address**
Robert W. Robertson, M.D., Paducah, KSMA president

10:00 **Visit Exhibits**

PANEL DISCUSSION

10:30 **Panel—"Biliary Tract Disease"**
Malcolm M. Stanley, M.D., Louisville, moderator
Campbell Gardner, M.D., Montreal, Que.
J. T. Ling, M.D., Louisville
Daniel C. Moore, M.D., Seattle, Wash.

11:50 **Luncheon**

2:00 SPECIALTY GROUP MEETINGS

Six specialty groups will present scientific programs simultaneously and there will be no general session. Programs will be held either in the First Christian Church or the Columbia Auditorium.

Meetings will start at 2:00 p.m. with 30 minute intermissions to visit exhibits scheduled. KSMA members are free to go from one group to another during the sessions.

Kentucky Society of Anesthesiology

First Christian Church Annex, Room 31

2:00 **"The Use of Hypnosis in Pediatric Anesthesia"**
David R. Nagle, M.D., Lexington

2:30 **"Recent Investigations at the University of Louisville, Section on Anesthesiology"**
Eugene Conner, M.D., Louisville, and resident staff, Louisville General Hospital

3:30 **Visit Exhibits**

4:00 **"Policies and Plans of the American Society of Anesthesiologists"**
Daniel C. Moore, M.D., Seattle, Wash.

GUEST SPEAKERS

SAMUEL BENJAMIN FOWLER, M.D.
Nashville, Tenn.



Private practice in orthopoedic surgery, 1947 to present; assistant professor of clinical orthopaedic surgery at Vanderbilt University School of Medicine; graduate University of Tennessee College of Medicine, 1937; internship, Nashville General Hosp., 1938-9; residency, Orthopaedic Hospital of Los Angeles, 1939-42; certified, American Board of Orthopaedic Surgery, 1948; Assistant Chief of Orthopoedic Surgery, Chief of Surgery at the Hand, both at Newton D. Baker and Valley Forge Hospital, 1944-47; post president, American Society for Surgery of Hand and Orthopoedic Section, Southern Medcial Association.

HERBERT SLOAN, M.D.
Ann Arbor, Mich.

Assaciate professor of surgery, University of Michigan; graduate, Johns Hopkins University School of Medicine, 1940; internship and residency, Johns Hapkins Hospital, 1940-44. Resident in thorocic surgery, University of Michigan Hospital, 1947-9; certified American Board of Surgery, 1948; Board af Thorocic Suregry, 1950; member American Surgical Association, American College of Surgeons; American Assaciation for Thorocic Surgery; Society of University Surgeons; U.S. Army, 1944-47, final rank of majar.



MALCOLM McCLAIN STANLEY, M.D.
Louisville, Ky.



Professar of experimentol medicine, University af Louisville School of Medicine; graduate University of Louisville with M.D., in 1941; former Associate professor of medicine, Tufts College School of Medicine, 1954-7; farmer physician, New England Center, Boston; certified, American Board of Internal Medicine, 1951; member American Society for Clinical Investigatian; Fellow American Cancer Society, Joseph H. Pratt Diagnostic Hospital, 1946-48. Native af Hendersan, Ky.; Associate, American College of Physicians.

Kentucky Chapter, American College of Chest Physicians

First Christian Church—Choir Room

2:00 "Trauma to the Chest"
James Holloway, M.D., Lexington

2:30 "Kentucky Tuberculosis Problem"
Adam Miller, M.D., Lexington

3:00 Visit Exhibits

Columbia Auditorium

3:30 JOINT MEETING WITH KY. CHAPT., AMERICAN ACADEMY OF PEDIATRICS
Harry S. Andrews, M.D., Louisville, and Walker Porter Mayo, M.D., Lexington, presiding

Round Table Discussion—"Open Heart Surgery"
Nelson K. Ordway, M.D., New Haven, Conn.
Herbert Sloan, M. D., Ann Arbor, Mich.

Kentucky Obstetrical and Gynecological Society

First Christian Church, Fellowship Hall

2:00 "Prevention of Abortion"
Robert E. L. Nesbitt, M.D., Albany, N. Y.

2:30 "Complications of Intrauterine Radium Used in Benign Lesions"
Harold W. Baker, M.D., Louisville

3:00 Visit Exhibits

3:30 Panel—"Perinatal Mortality"
W. E. Oldham, M.D., Louisville, moderator
Robert E. L. Nesbitt, M.D.
Harold W. Baker, M.D.
Robert Monroe, M.D., Louisville

Kentucky Orthopaedic Society

First Christian Church Annex, Room 36

2:00 "Solitary Bone Cyst"
K. Armand Fischer, M.D., Louisville

2:30 "The Brewster Foot Stabilization Operation"
Daniel G. Costigan, M.D., Louisville

3:00 Visit Exhibits

3:30 "Discography"
William K. Massie, M.D., Lexington

4.00 "The Cavo Varus Foot"
S. Benjamin Fowler, M.D., Nashville, Tenn.

Kentucky Chapter, American Academy of Pediatrics

Columbia Auditorium Building—Auditorium

2:00 "Acid Base Disturbances in Children"
Nelson K. Ordway, M.D., New Haven, Conn.

3:00 Visit Exhibits

3:30 JOINT MEETING WITH KY. CHAPT., AMER. COLLEGE OF CHEST PHYSICIANS
Harry S. Andrews, M.D., Louisville, and W. Porter Mayo, Lexington, presiding

Round Table Discussion "Open Heart Surgery"
Nelson K. Ordway, M.D.
Herbert Sloan, M.D., Ann Arbor, Mich.

Kentucky Chapter, American College of Surgeons

First Christian Church Annex, Room 28

2:00 "Ten Years' Experience with Hip Fractures in A Rural Hospital"
C. C. Lowry, M.D., Murray

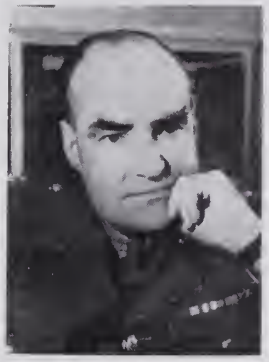
2:30 "Modern Concepts on the Treatment of Hepatic Coma in Surgical Patients
Martin S. Kleckner, Jr., M.D., Paducah

3:00 Visit Exhibits

3:30 "Gastric Ulcer—To Operate or Not to Operate and When"
Campbell M. Gardner, M.D., Montreal

4:00 "Arterial Anastomosis with the Use of Silk and Nylon Sutures"
Jose L. Romero, M.D., Louisville

CAMPBELL GARDNER, M.D.
Montreal, Canada



Chief Surgean, Queen Mary Veterans Hospital; assistant profassar, surgery, McGill University, assaciate surgean, Mantreal General Haspital. A native af Mantreal. Graduated McGill in 1931 with M.D., C.M.; did pastgraduate wark at Mantreal General Hasp., in England, Eurape, and the United States. Obtained F.R.C.S.—in England, 1936—Canada, 1939. A retired lieutenant calanel in Canadian Army. Authar af many scientific papers. Fellaw in American Callege af Surgeons.

J. T. LING, M.D., M.S.C.
Louisville, Ky.

Assaciate profassar af radialagy, University af Lauisville Schaal af Medicine; Assaciate radialagist, Lauisville General Haspital; graduate, St. Jahn's Medical Schaal, 1942; American Baard af Radialagy, 1949; interned St. Luke's Haspital, Shanghai; residency, DePaul Haspital, Narfalk, Va., member, American Callege af Radialagy; Radialagical Society af Narth America.



DANIEL C. MOORE, M.D.
Seattle, Wash.



President af American Saciety of Anesthesialagists; Directar, anesthesia, Virginia Masan Hospital, Seattle, 1947 ta present; Anesthesialagist, the Masan Clinic, 1947 ta present; graduate Narthwestern University with M.D., 1944; Captain, U.S. Army Med. Carps, 1945-57; Diplamate, American Baard of Anesthesialagists 1948; Secretary af the sectian an anesthesialagy, AMA, 1957-8; president, Washingtan State Saciety af Anesthesialagists, 1949-50; farmer vice president and president-elect af the Am. Society af Anesthesialagists.

NELSON K. ORDWAY, M.D.
New Haven, Conn.

Professar af pediatrics, Yale University Schaal af Medicine; professar af pediatrics, University af Narth Caralina Schaal af Medicine, 1954-7; Dept. af Pediatrics, Lauisiana State University, 1947-1954; M.D. degree cum laude, Yale University Schaal af Medicine, 1938; intern in pediatrics, New Haven Haspital, and assistant in pediatrics, Yale U Schaal af Medicine, 1938-9; ratating intern University af Pennsylvania Haspital, 1939-41; member, editarial baard, "Pediatrics"; certified American Baard af Pediatrics, 1953.



WEDNESDAY, SEPTEMBER 23

SECOND SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

9:00 A.M.

Marvin Lucas, M.D., Louisville, vice president (central), presiding

SCIENTIFIC PAPERS

9:00 **"Forensic Pathology, The Function and Responsibility of the Coroner's Office"**
Frank P. Cleveland, M.D., Cincinnati, Ohio

9:20 **"Evaluation of Growth and Development in Children"**
Nelson K. Ordway, M.D., New Haven, Conn.

9:40 **"Recent Advances in Gastrointestinal Roentgenology"**
Richard Harvey Marshak, M.D., New York, N. Y.

10:00 **Visit Exhibits**

10:30 **Clinicopathologic Conference**
John D. Allen, Jr., M.D., Louisville, moderator
Carlos A. Fish, M.D., Louisville, discussant
Robert J. Ritterhoff, M.D., Covington, pathologist
Richard H. Marshak, M.D., radiologist

President's Luncheon

BALLROOM—BROWN HOTEL

11:50 A.M.

Robert W. Robertson, M.D., Paducah, presiding

Invocation
Dr. Kenneth G. Phifer, Presbyterian Seminary, Louisville

Recognitions
Robert W. Robertson, M.D.

Awards Presentations
Woodford B. Troutman, M.D., Louisville, KSMA secretary

"Activities of the Office of the Assistant Secretary of Defense (Health and Medical)"
Frank B. Berry, M.D., Washington, D. C.

THIRD SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

2:00 P.M.

T. O. Meredith, M.D., Harrodsburg, vice president, (Eastern), presiding

SCIENTIFIC PAPERS

2:00 **"Chronic Inflammatory Lesions of the Large Bowel"**
Campbell Gardner, M.D., Montreal

2:20 **"Pedodontics Grows Up: The Science of Dentistry for Children"**
Henry M. Wilbur, D.D.S., Louisville

2:40 **"Detection and Diagnosis of Early Cervical Cancer"**
Robert E. L. Nesbitt, Jr., M.D., Albany, N. Y.

3:00 **Visit Exhibits**

3:30 **"Problems in the Recognition of Acute Pericarditis"**
William A. Sodeman, M.D., Philadelphia, Pa.

3:50 **"The Practical Application of Medicine to Jet Transportation"**
Kenneth L. Stratton, M.D., Flushing, N. Y.

4:10 **"Ocular Inflammation" (with movie)**
John H. King, M.D., Washington, D. C.

4:40 **Motion Picture — "Whale Electrocardiogram" — Walker Laboratories**

RICHARD H. MARSHAK, M.D.
New York City, N. Y.



Associate roentgenologist, Mount Sinai Hospital, New York City; graduate, University of Louisville School of Medicine, 1937; internship and residency in radiology at Mount Sinai Hospital; Fellow, American College of Radiology; member, American Roentgen Ray Society; North American Radiological Society; American Gastroenterological Society; chairman, Scientific Exhibits Committee, American Roentgen Ray Society; member, editorial board, American Journal of Digestive Diseases; author, 84 papers.

JOHN D. ALLEN, JR., M.D.
Louisville, Ky.



Pathologist and director of laboratories, Kentucky Baptist Hospital, 1951 to present; graduate of Harvard Medical School, 1941; intern Cincinnati General Hospital; Fellow in pathology, Boston City Hospital, 1947-8; Assistant pathologist, St. Anthony Hospital, 1948-9; Trainee, National Cancer Institute, Memorial Hospital for Cancer and Allied Diseases, New York, 1950; Flight Surgeon, USAAF, 1942-6; Diplomate, American Board of Pathology, 1954; member College of American Pathologists; President-elect, Kentucky Society of Pathologists.

CARLOS A. FISH, M.D.
Louisville, Ky.



Assistant clinical professor of medicine, University of Louisville School of Medicine; M.D. degree, University of Louisville School of Medicine, 1936; internship and residency, Louisville General Hospital, 1936-8; Fellowship in medicine, Hospitol of University of Pa., 1938-40; Lt. Col. Med. Corps, AUS, World War II; Native of Frankfort, Ky.; certified, American Board of Internal Medicine, 1943; Fellow, American College of Physicians, 1951.

ROBERT J. RITTERHOFF, M.D.
Covington, Ky.



Pathologist, St. Elizabeth Hospital, Covington; Assistant Professor in Pathology, College of Medicine, University of Cincinnati; Consultant Pathologist, U.S. Veterans Hospital, Dayton, Ohio; graduate, University of Cincinnati College of Medicine, 1937; Member, American Association of Pathologists and Bacterialogists and American Society of Clinical Pathologists.

THURSDAY, SEPTEMBER 24

9:00 Specialty Group Meetings

Six specialty groups will meet simultaneously on Thursday morning and there will be no general session. Programs will be held in the First Christian Church, the First Unitarian Church, or the Columbia Auditorium.

Sessions will run from 9:00 to 11:50 with a half-hour intermission to visit exhibits at 10:00. All members are welcome to attend any of these sessions.

Kentucky EENT Society

First Christian Church, Room 28

8:30 Executive Session

9:00 "Conservation of Hearing in the Clinically Infected Ear with Special Reference to Tympanoplasty"
Thomas E. Booth, M.D., Louisville

9:30 "Lamellar Corneal Transplants — An Unknown Tool"
John Harry King, Jr., M.D., Washington, D.C.

10:00 Visit Exhibits

10:30 "Dizziness"
Gordon D. Hoople, M.D., Syracuse, N. Y.

11:00 "Neuro-ophthalmic Evaluation of Abducens Nerve Paralysis"
Edward C. Shrader, M.D., Louisville

11:30 Business meeting

Kentucky Chapter, American Academy of General Practice

Columbia Auditorium Building—Auditorium

9:00 "Therapy of Macrocytic Anemias"
Marion F. Beard, M.D., Louisville
"Therapy of Microcytic Anemias"
Thomas Stevenson, M.D., Louisville

9:30 "Therapy of Multiple Myeloma"
Wayne R. Rundles, M.D., Durham, N. C.
"Therapy of Leukemias and Lymphomas"
Henry D. Diamond, M.D., New York, N. Y.

10:00 Visit Exhibits

10:30 Panel—"Blood Dyscrasias"
Benjamin F. Roach, M.D., Midway, moderator
Marion F. Beard, M.D.
Henry D. Diamond, M.D.
Wayne R. Rundles, M.D.
Thomas Stevenson, M.D.

Kentucky Society of Pathologists

First Christian Church, Room 36

9:00 "The Forensic Pathologist—A Medical Detective"
Frank P. Cleveland, M.D., Cincinnati, Ohio

9:45 "Primary Pulmonary Infection with Monosporium Apiospermum, one of the agents of Maduromycosis
Modesto Scharyj, M.D., Louisville

10:05 "Pediatric Pulmonary Problems—Their Nature and Their Solution"
Israel Diamond, M.D. ,Louisville

10:30 Visit Exhibits

11:00 "Interference Microscopy in Cytopathology"
W. M. Christophersen, M.D., Louisville, and Walter Broghamer, B. S., Louisville

11:20 "Mammary Adenoma of Pregnancy"
James E. Parker, M.D., Louisville

11:40 "A Study of Circulating Cancer Cells in Peripheral Blood"
B. J. Nedelkoff, M.D., Louisville

HENRY M. WILBUR, D.D.S., M.S.
Louisville, Ky.



Professor of dentistry ond head of the Department of Pedodontics, and director of graduote ond postgraduote education, University of Louisville School of Dentistry; Graduate of the University of Michigan School of Dentistry. Has Michigan U specialty degree in Pedodontics. Hos held numerous offices in American Society of Dentistry for Children, including the presidency in 1955; charter member and post president, Kentucky Society of Dentistry for Children and American Academy of Pedodontics.

ROBERT E. L. NESBITT, JR., M.D.
Albany, N. Y.



Professor and chairmon, Dept. of Obstetrics and Gynecology, Albany Medicol College of Union University; Obstetrician and Gynecologist-in-Chief, Albany Hospital; graduate, Vanderbilt Medical School, Noshville, Tenn., 1947; rotating internship, Baltimore City Hospital, 1947; residency, ob-gyn, Johns Hopkins Hospital; one of 10 outstanding Young Men in America selected by Junior Chamber of Commerce, 1957; Fellow, American College of Obstetrics ond Gynecology; Diplomate, Am. Board of Obstetrics and Gynecology, 1956.

WILLIAM A. SODEMAN, M.D.
Philadelphia, Pa.

Dean, the Jefferson Medical College, Philodelphia; former Magee professor of medicine and head of the department, Jefferson Medical College. Groduoted from University of Michigan with M.D. in 1931. Interned St. Vincent's Hospital, Toledo, Ohio. Formerly professor and chairman of Dept. of Internal Medicine, U of Missouri. A founding member of Southern Society for Clinicol Research and past president of Southern Section, Society for Experimental Biology and Medicine; Fellow, Am. College of Physicians.



KENNETH L. STRATTON, M.D.
New York City, N. Y.



Medical Director, American Airlines; graduote, University of Louisville School of Medicine in 1935; in private proctice, northern Ky. and southern Ohio until 1942; Army Air Force, 1942-6, flight surgeon, Alaskon Division of Air Transport Commond; and former commanding officer of station hospital, Stockton, Calif.; Lt. Col. in USAF reserve; Member, Founder Group in Aviation Medicine of the American Board of Preventive Medicine; Author of severol orticles on medicine and aviation; Fellow Aero Space Medical Association; member ond past president of the Airlines' Medicol Directors Associotion.

JOHN HARRY KING, JR., M.D.
Washington, D. C.



Associate clinical professar af aphthalmalagy, Geargetawn University Medical Schaal; chrm., research cammittee, Washingtan Haspital Center; secretary, Joint Cammittee an Eye Banks; consultant ta the surgean general, U.S. Army and U.S. Air Farce; graduate Geargetawn University 1934; diplamate, American Baard af Ophthalmalagy; Fellaw, American College af Surgeans; Calanel, U.S. Army Medical Carps, retired after 20 years' service; past chief af Eye Service, Walter Reed Army Haspital; authar af twa manuals an eye surgery and over 50 scientific articles.

FRANK P. CLEVELAND, M.D.
Cincinnati, Ohio

Associate prafessar af Farensic Pathalagy, University af Cincinnati College af Medicine; Staff physician, Cincinnati General Haspital; Graduated University af Pittsburgh Schaal af Medicine, 1944; Internship, Mercy Haspital, Pittsburgh, Pa., 1944-5; Resident in Pathalagy, Cincinnati General Haspital 1947-9; AVS, Captain, Medical Carps, 1945-7; Certified, Pathalagic Anatamy, American Baard af Pathalagy, 1951; Assist. Caroner and Pathalagist far the Caraner af Hamiltan Caunty, Ohio, 1948 ta present.



ROBERT SLOCUM GARBER, M.D.
Belle Mead, N. J.



Part time medical directar, the Carrier Clinic, Belle Mead, N. J., former superintendent, N. J. Neuropsychiatric Institute, Skillman, until retirement in July, 1958 after 20 years state service; graduated Jefferson Medical College, 1937; residency Trenton State Haspital, 1938-42; U.S. Army, 1942-1946; discharged as Lt. Calanel; Diplamate, American Baard af Psychiatry and Neuralagy, 1947; Fellaw af the American Psychiatric Association; Certified Mental Haspital Administratar; Chairman Haspital Cammittee, Graup far Advancement af Psychiatry.

J. R. HELLER, M.D.
Bethesda, Md.

Directar, Natianal Cancer Institute, Natianal Institutes af Health, U.S. Public Health Service, Dept. af Health, Educatian and Welfare; Assistant surgean general, U.S. Public Health Service; graduate, Emary University Schaal af Medicine, Atlanta, Ga., 1929; interned, Sauthern Pacific Hasptial, San Francisca; residency, Mills Memarial Haspital, San Matea, Calif., and Jahns Hapkins Hasp., Baltimare, Md.; Directar-at-large, Am. Cancer Saciety; Diplamate, American Baard af Preventive Medicine and Public Health, Prafessianal lecturer, Gea. Washingtan University Schaal af Medicine, 1948 ta present.



Kentucky Chapter, American College of Physicians

First Unitarian Church, Breaux Hall

9:00 **"The Several Faces of Multiple Myeloma"**
David W. Parsons, M.D., Madisonville

9:30 **"Hyperventilation Syndrome"**
William A. Sodeman, M.D., Philadelphia, Pa.

10:00 **Visit Exhibits**

10:30 **"Clinical Picture and Pathogenesis of Manson's Schistosomiasis"**
R. S. Diaz-Rivera, M.D., San Juan, Puerto Rico

11:00 **"Chronic Non-Tuberculous Pulmonary Disease"**
Richard E. Mardis, M.D., Louisville

Kentucky Psychiatric Association

First Christian Church, Fellowship Hall

9:00 **"A Psychiatrist's Work with the Juvenile Court"**
Robert J. Lehman, M.D., Louisville

9:45 **"The Department of Psychiatry at the University of Kentucky Medical School"**
Joseph M. Parker, III, M.D.

10:00 **Visit Exhibits**

10:30 **"What the Pyschiatrist Has to Offer the General Physician"**
Robert S. Garber, M.D., Belle Mead, N. J.

Kentucky Public Health Physicians

First Christian Church—Choir Room

9:00 **"Newer Diagnostic Services of the State Health Department Laboratories"**
Emil Kotcher, Sc. D., Louisville

9:30 **"Cancer Control"**
J. R. Heller, M.D., Bethesda, Md.

10:00 **Visit Exhibits**

10:30 **Panel—"Integration of Home Care Services into the Public Health Program in the County Health Departments"**
Edwin Cameron, M.D., Louisville, moderator
Frederick W. Wilt, M.D., Georgetown
Kathleen Vaughan, R. N., Georgetown
Mildred Neff, director of nutrition, State Department of Health, Louisville

11:50 **Lunch**

FOURTH SCIENTIFIC SESSION

COLUMBIA AUDITORIUM

2:00 P. M.

L. F. Beasley, M.D., Franklin, vice president (Western), presiding

2:00 **"Building an Effectual Physician - Psychiatrist Team"**
Robert S. Garber, M.D., Belle Mead, N. J.

2:20 **"Progress in Cancer Research"**
J. R. Heller, M.D., Bethesda, Md.

2:40 **"The Clinical Use of the Oral Nitrogen Mustard Compounds in Malignant Diseases"**
Wayne R. Rundles, M.D., Durham, N. C.

3:00 **Visit Exhibits**

PANEL DISCUSSION

3:30 **"Reversible Renal Failure"**
Beverly T. Towery, M.D., Louisville, moderator
William A. Sodeman, M.D., Philadelphia, Pa.
Wayne R. Rundles, M.D., Durham, N. C.
Edmund D. Pellegrino, M.D., Lexington, Ky.

5:00 **Adjournment**

R. WAYNE RUNDLES, M.D.
Durham, N. C.



Professar af medicine in charge af Hematalagy Labaratary; Duke University Schaal af Medicine; graduate af Duke Schaal af Medicine with M.D. in 1940; internship, assistant residency, and residency, University af Michigan, 1940-3; instructar in medicine and research assistant, Simpsan Memarial Institute, U af Mich., 1943-5; Dept. Med. Duke, 1945 ta present; daes teaching and research in blaad diseases, chematherapy af neaplastic disease; publicatians, neuraanatamy, metabalism, and hematalagy. Native af Urbana, Ill.

BEVERLY TODD TOWERY, M.D.
Louisville, Ky.

Prafessar and chairman, Dept. af Medicine, University af Louisville, Schaal af Medicine; graduate, Vanderbilt University Schaal af Medicine, M.D., summa cum laude, 1940; internship, Vanderbilt, 1940-41; resident in pathalagy, Bastan City Haspital, 1941-2; asst. resident physician in medicine, Massachusetts General Haspital, 1946; resident physician in Bastan City Haspital, U.S. Army Med. Carps, 1941-5, rank af majar; Vanderbilt University Haspital, 1949-56; Assaciate Prafessar af Medicine, Vanderbilt, 1954-6; certified, American Baard af Internal Medicine, 1950.



E. D. PELLEGRINO, M.D.
Lexington, Ky.



Prafessar and Chairman, Department af Medicine, University af Kentucky Callege af Medicine; graduate, New Yark University Callege af Medicine, 1944; internship and residency, New Yark University Divisian, Bellevue Haspital; chief af Medical Service, USAF Haspital, Mantgamery, Ala., 1946-48; Medical directar and directar af internal medicine, Hunterdan Medical Center, Flemingtan, N. J., 1953-9; Assist. Praf. af Clinical Medicine, New Yark University, 1953-59; majar field af interest, cardiavascular renal disease.

Panel Featured at Luncheon for New Members

The KSMA will honor new members of the association at the first annual luncheon for New Members which will be held in the Louis XVI Room of the Brown Hotel on September 22.

All KSMA members who joined after September 1, 1958 are cordially invited to attend the luncheon which has been planned in their honor by a committed headed by N. L. Bosworth, M.D., luncheon chairman.

Doctor Bosworth will moderate a short panel discussion on the various services the KSMA offers during the luncheon. Panel participants will include: Carl Fortune, M.D., "The Purpose of the KSMA"; Hoyt D. Gardner, M.D., Louisville, "Services that the KSMA Renders Its Members"; and Garnett Sweeney, M.D., "Services the KSMA Offers to the Public."

Individual invitations will be received by all new members of KSMA, Doctor Bosworth said, well before the meeting.

A list of all new members will appear in the September issue.

Alumni Reunion Chairmen, Plans Announced for U of L Classes

Alumni reunion chairmen and a guest speaker for the annual alumni dinner for 10 five-year classes of the University of Louisville Medical School in the Crystal Ballroom of the Brown Hotel have been announced by Les Shively, director of alumni relations at the University.

Bart Brown, Senior Vice President of the Citizens Fidelity Bank and Trust Company, Louisville, will be featured speaker at the dinner. All KSMA members are invited to attend the cocktail party in the South Room which will precede the dinner. The cocktail party is sponsored by the faculty of the medical school.

Classes holding reunions this year include the class of 1909 which is the 50th reunion class and the class of 1934 which is celebrating its 25th. Reunions of the classes of 1909, 1914, and 1919 are being handled by the alumni office.

Other alumni reunion chairmen for this year are:

1924, Stanley T. Simmons, M.D., Louisville

1929, Max Garon, M.D., and Margaret Limper, M.D., Louisville

1934, Rudolph F. Vogt, M.D.

1939, Bruce B. Mitchell, M.D., Louisville

1944, Charles Bruce, M.D., Louisville

1949, Charles Floyd, M.D., Gulfport, Miss.

1954, William J. Sandman, Jr., M.D., Louisville.

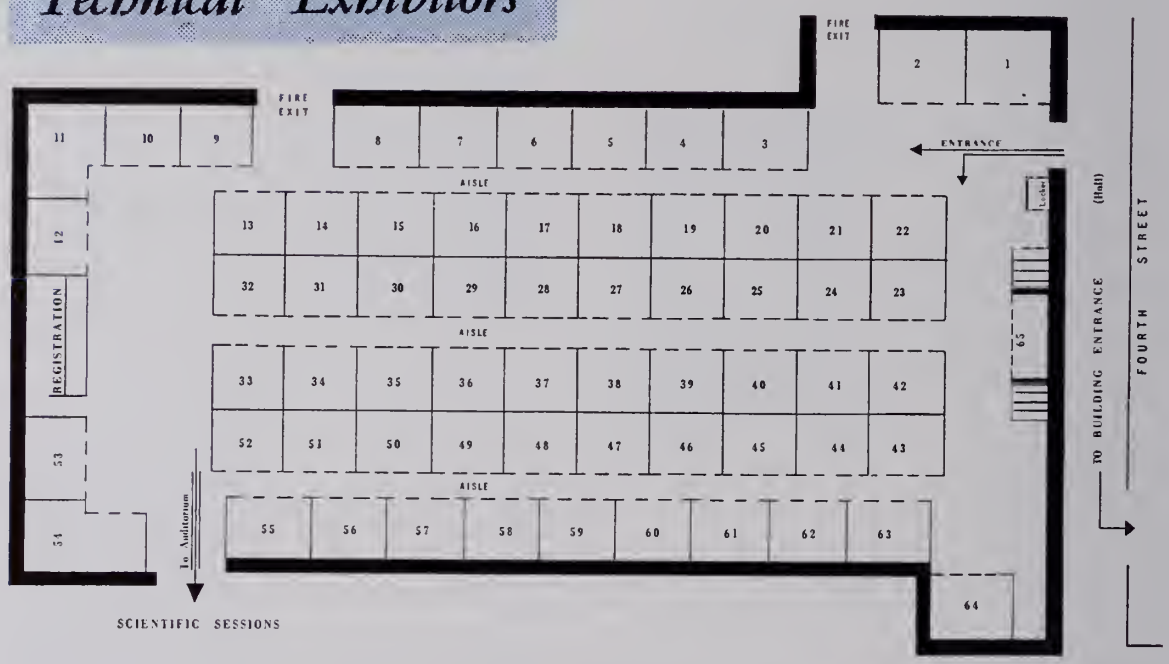
Visit the Scientific and Technical Exhibits

Scientific Exhibitors

(Located to the right of main entrance)

1. **Surgery of the Hand**
   J. Thomas Giannini, M.D., Louisville
2. **Which Rheumatic Disease?**
   William P. Peak, M.D., Louisville
3. **Cancer Cells—Cytology, Cervix**
   Malcolm L. Barnes, M.D., and Robert C. Long, M.D., Louisville
4. **McDowell House and Apothecary Shop**
   Francis M. Massie, M.D., Lexington
5. **Common Eye Tumors**
   Arthur H. Keeney, M.D., Edward C. Shrader, M.D., Charles O. Bruce, M.D., Louisville
6. **Simple Episiotomy**
   W. E. Becknell, M.D., and J. L. Becknell, M.D., Manchester
7. **Practical Value of Pulmonary Function Testing**
   William H. Anderson, M.D., Harlan
8. **Cause and Correction of Congenital Hydronephrosis**
   Robert Lich, Jr., M.D., and Malcolm L. Barnes, M.D., Louisville
9. **Perfusion Therapy in Carcinoma**
   Benjamin B. Jackson, M.D., and Walter I. Hume, M.D., Louisville
10. **Kentucky Children's Heart Clinic**
    Joseph A. Little, M.D., Louisville
11. **Restorative Arterial Surgery**
    J. Herman Mahaffey, M.D., Louisville

Technical Exhibitors



Floor plan showing booth spaces of 1959 KSMA Technical Exhibitors

Abbott Laboratories (32)
A. S. Aloe Company (8)
Ames Company, Inc. (10)
Arnar-Stone Laboratories (26)
Ayerst Laboratories (51)
Baker Laboratories, Inc. (60)
Blue Cross Hospital Plan, Inc. (27)
Burton, Parsons & Company (49)
Burroughs Wellcome & Company (22)
Carrtone Laboratories, Inc. (5)
The Central Pharmacal Company (50)
Chicago Pharmacal Company (17)
Ciba Pharmaceutical Products, Inc. (9)
Coca-Cola Company (64)
Crocker-Fels Company (29)
The Doho Chemical Corporation (30)
Eaton Laboratories (45)
C. B. Fleet Company, Inc. (41)
Geigy Pharmaceuticals (47)
General Electric Company (44)
Guild of Prescription Opticians of Ky. (39)
John Hancock Insurance Company (65)
Johnson and Johnson (6)
Kay Surgical, Inc. (11)
Lederle Laboratories (3)
Eli Lilly and Company (52)
J. B. Lippincott Company (58)
Logan Company, Sealy Div. (57)
McNeil Laboratories, Inc. (61)
J. A. Majors Company (1)
Malkin Instrument Company (48)
Maltbie Laboratories Div. (15)
S. E. Massengill Company (37)
Mead Johnson & Company (62)
Medical Protective Company (20)
Merck Sharp & Dohme (42)
William S. Merrell Company (24)
Miller Surgical Company (19)
C .V. Mosby Company (12)
Ortho Pharmaceutical Corporation (34)
Parke, Davis and Company (13)
Pfizer Laboratories (2)
R. J. Reynolds Tobacco Co. (38)
A. H. Robins Co., Inc. (21)
J. B. Roerig & Company (4)
William H. Rorer, Inc. (59)
Ross Laboratories (7)
Sandoz Pharmaceuticals (35)
Schering Corporation (33)
Julius Schmid, Incorporated (36)
G. D. Searle & Company (53)
Smith, Kline and French Laboratories (43)
Smith, Miller & Patch, Inc. (28)
E. R. Squibb and Sons (63)
Theodore Tafel (31)
Thermo-Fax Sales Co. (18)
The Upjohn Company (55)
U. S. Tobacco Company (16)
U. S. Vitamin Corporation (54)
Vanpelt and Brown, Inc. (14)
Warner-Chilcott Laboratories (40)
Westwood Pharmaceuticals (46)
Winthrop Laboratories (23)
Max Wocher & Son Company (56)
Zimmer Manufacturing Company (25)

Annual KSMGA Golf Tourney



Big Spring Golf Club on Dutchman's Lane in Louisville has been selected for play in the annual KSMGA tournament during the Annual Meeting on September 23, 24, and 25.

Golf Committee to Host Tourney at Big Spring Golf Club

Members of the KSMA Golf Committee will play host to participants in the 1959 KSMGA golf tournament at Big Spring Golf Club on September 22, 23, and 24.

The host method is an innovation this year, according to Lanier Lukins, M.D., Louisville, golf committee chairman. Members of the committee who will be serving as hosts include: Harold Baker, M.D., Louisville; Clifton G. Follis, M.D., Glasgow; Merle W. Fowler, Jr. M.D., Glasgow; Martin Kaplan, M.D., Louisville; Kenton D. Leatherman, M.D., Louisville; William C. Wolfe, M.D., Louisville; and Robert M. Wooldridge, M.D., Paducah.

Golf dues have been increased to $6 this year, with the increase taking care of the green fee in addition to the dues, resulting in an actual reduction in cost per golfer this year.

The usual prizes, plus one year's possession of traveling trophies will be awarded to those winning top honors in the low gross, low net, and senior championship categories.

Golfers wishing to play should send the attached application blank to the KSMA headquarters office enclosing the $6 in dues.

CLIP HERE

APPLICATION FOR MEMBERSHIP
KSMA Golf Association

(Please complete and return immediately)

to: KSMA Golf Committee
Kentucky State Medical Association
1169 Eastern Parkway
Louisville 17, Kentucky

Name .....

Street .....

Town .....

Cash enclosed is $6.00..... Check, $6.00.....

During the 1959 annual KSMA Golf Tournament, I would like to play September 22, 23, or 24. (circle day or dates)

PROGRAM

THIRTY-SEVENTH ANNUAL MEETING WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

BROWN HOTEL
LOUISVILLE, KENTUCKY
September 22, 23, 24, 1959

REGISTRATION:
North Bay of Lobby, Brown Hotel
Monday 12 noon to 5 P.M.
Tuesday 8:30 A.M. to 5 P.M.
Wednesday 9 A.M. to 12 Noon

Hospitality Room open:
Tuesday 10 A.M. to 5 P.M.
Wednesday 9 A.M. to 12 Noon

TUESDAY, SEPTEMBER 22

8:45 A.M.
PARLORS A B C, BROWN HOTEL

Preconvention Board Breakfast (subscription). The Board consists of all general state officers, councilors, state committee chairmen, county auxiliary presidents, *and three immediate past presidents.*

10:30 A.M.
SOUTH ROOM

Formal opening of the 37th Annual Meeting of the Woman's Auxiliary to the Kentucky State Medical Association.

Presiding ..... Mrs. Jesse T. Funk, Bowling Green

Invocation ..... Mrs. Arthur L. Cooper, Somerset, Councilor District XII

Pledge of Allegiance to the Flag . Mrs. Charles B. Stacy, Pineville

"I pledge allegiance to the flag of the United States of America and to the Republic for which it stands. One Nation, under God, indivisible, with liberty and justice for all."

Pledge of Loyalty ..... Mrs. Charles B. Stacy

"I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals."

Address of Welcome ..... Mrs. Harry A. Pfingst, Louisville, President Jefferson County Auxiliary

Response ..... Mrs. William H. Cartmell, Maysville, Chairman Registration

In Memoriam ..... Mrs. John Barbee, Bowling Green, President of Warren Co. Auxiliary

Presentation of Convention Chairmen:
Mrs. J. Murray Kinsman, Louisville, Convention Chairman

Presentation of Distinguished Guests.

Roll Call ..... Mrs. Merle M. Mahr, Madisonville, Secretary

Minutes of the 36th Annual Meeting Mrs. Merle M. Mahr

Report of the 1958 National Convention:
Mrs. Karl D. Winter, Louisville, Editor of "Bluegrass News"

Report of the Councilor of the Woman's Auxiliary to the Southern Medical Association .. Mrs. Robert F. Monroe, Louisville, Councilor from Kentucky

REPORT OF OFFICERS:

Treasurer ..... Mrs. Carlisle Morse, Louisville

President-Elect & Organization Chairman ..... Mrs. Charles B. Johnson, Russell

President ..... Mrs. Jesse T. Funk

Old Business.

New Business

Report of the Nominating Committee:
Mrs. J. Andrew Bowen, Louisville, Chairman

Election of Nominating Committee for 1959-60

Presentation of 1959-60 Budget..... Mrs. B. T. Harris, Lexington, Finance Chairman

Report of Registration..... Mrs. William H. Cartmell

Reports of State Chairmen—Exhibit Walk

12:30 P.M.
SOUTH ROOM—SUBSCRIPTION LUNCHEON
IN HONOR OF

Mrs. George W. Owen..... Jackson, Mississippi President, Woman's Auxiliary to the Southern Medical Association.

Invocation ..... Mrs. E. W. Garred, Catlettsburg, Councilor District III

Address ..... Mrs. George W. Owen

2:00 P.M.
SOUTH ROOM

Reports of County Auxiliary Presidents
Slides

3:30 P.M.
LOUIS XVI ROOM

Tea Honoring Distinguished Guests.. Clark Co. Hostesses
All Physicians' Wives Invited.

WEDNESDAY, SEPTEMBER 23

9:00 A.M.

SOUTH ROOM

Invocation .....Mrs. Russell H. Davis, Pikeville, Immediate past president—Pike County Auxiliary
Roll Call .....Mrs. Merle M. Mahr
Reading of Minutes .....Mrs. Merle M. Mahr
Announcements .....Mrs. J. Murray Kinsman Louisville Convention Chairman
Address .....R. W. Robertson, M.D. Paducah, KSMA President
Address .....Mrs. William Mackersie, President-Elect Woman's Auxiliary to the American Medical Association
Election of Officers
Presentation of Distinguished Guests
Installation of Officers.....Mrs. William Mackersie
Inaugural Address .....Mrs. Charles B. Johnson
Announcement of Committee Chairmen: Mrs. Charles B. Johnson
Final Report of Registration..Mrs. William H. Cartmell
Adjournment

12:25 P.M.

Buses leave Brown Hotel for Fairgrounds
Bus transportation courtesy of The Crocker-Fels Company and Dick X-ray Company

1:00 P.M.

MASON-DIXON ROOM, FREEDOM HALL, FAIRGROUNDS

SUBSCRIPTION LUNCHEON AND TRAVEL FASHION SHOW IN HONOR OF

Mrs. William Mackersie, Detroit, Michigan
President-Elect, Woman's Auxiliary to the American Medical Association

Mrs. George W. Owen, Jackson, Mississippi, President, Woman's Auxiliary to the Southern Medical Association
Past Presidents of the Woman's Auxiliary to the Kentucky State Medical Association
Invocation .....Mrs. Robert Salisbury Mt. Sterling Councilor, District XI

Presentation of Distinguished Guests
Presentation of Past Presidents
Presentation of Officers
Presentation of Health Citation Award: Mrs. William C. Cloyd Richmond, Chairman Award Committee
Style Show

THURSDAY, SEPTEMBER 24

9:00 A.M.

SOUTH ROOM

Post-Convention Board Breakfast and Meeting (Subscription)
Presiding .....Mrs. Charles B. Johnson

11:40 A.M.

Tour—General Electric and Farmington—Louisville
Luncheon at Executives Dining Room, General Electric (Buses leave and return 4:00 P.M.) Brown Hotel
Tickets on sale at Registration Desk
All Doctor's wives invited.
Bus transportation courtesy of W. E. ("Red") Davis—John Hancock Life Insurance Company

STATE CONVENTION COMMITTEE

General Chairman..Mrs. J. Murray Kinsman, Louisville
Registration ....Mrs. William H. Cartmell, Maysville
Luncheon .....Mrs. Robert S. Dyer, Louisville
Decorations and Flowers .Mrs. Walter S. Coe, Louisville
Finance .....Mrs. William C. Durham, Louisville
Publicity .....Mrs. Robert C. Long, Louisville
Hostesses for Tea.....Clark County Auxiliary
Hospitality Room ..... District Councilors
Hospitality for Out-of-State Guests: Mrs. Robert F. Monroe, Louisville; Mrs. William Ray Moore, Louisville
Tellers .....Mrs. J. Andrew Bowen, Louisville; Mrs. William Woolfolk, Owensboro; Mrs. R. E. Davis, South Carrollton
Pages .....Mrs. Louis O. Geisel, Louisville; Mrs. Max P. Jones, Louisville; Mrs. Raymond E. Jones, Louisville
Tour .....Mrs. Rex O. McMorris, Louisville

STATE OFFICERS 1958-59

President .....Mrs. Jesse T. Funk, Bowling Green
President-Elect .....Mrs. Charles B. Johnson, Russell
Vice-President ..... Mrs. Hugh Mahaffey, Richmond
Vice-President .....Mrs. C. J. Haebele, Russell
Vice-President .....Mrs. Guy Morford, Owensboro
Vice-President .....Mrs. Keith Smith, Corbin
Recording Secretary .....Mrs. Merle M. Mahr Madisonville
Corresponding Secretary ..... Mrs. William Russell Bowling Green
Treasurer .....Mrs. Carlisle Morse, Louisville
Parliamentarian .....Mrs. Irving Gail, Lexington

ADVISORY COMMITTEE

L. O. Toomey, M.D., Bowling Green
R. Ward Bushart, M.D., Fulton
Howard E. Dorton, M. D., Lexington

IMMEDIATE PAST PRESIDENTS

Mrs. R. Ward Bushart, Fulton
Mrs. Charles B. Stacy, Pineville
Mrs. J. Andrew Bowen, Louisville

DISTRICT COUNCILORS

1st—Mrs. R. Ward Bushart, Fulton
2nd—Mrs. C. C. Kissinger, Henderson
3rd—Mrs. C. C. Donovan, Central Sity
4th—Mrs. A. S. Holmes, Elizabethtown
5th—Mrs. Burford Davis, Louisville
6th—Mrs. R. O. C. Green, Bowling Green
7th—Mrs. Donald Chatham, Shelbyville
8th—Mrs. Robert Reichert, Covington
9th—Mrs. George E. Estill, Maysville
10th—Mrs. T. J. Overstreet, Lexington
11th—Mrs. Robert Salisbury, Mt. Sterling
12th—Mrs. Arthur L. Cooper, Somerset
13th—Mrs. E. W. Garred, Catlettsburg
14th—Mrs. Paul Hall, Paintsville
15th—Mrs. Daniel Bower, Williamsburg

COMMITTEE CHAIRMAN

American Medical Education Foundation—Mrs. Clyde Sparks, Ashland
Benevolence—Mrs. P. E. Blackerby, Louisville
Bulletin —Mrs. J. O. Mattax, Carrollton
Cancer—Chairman, Mrs. Marion G. Brown, Lexington; Co-Chairman, Mrs. William S. Swartz, Lexington

Civil Defense—Mrs. Charles Fisher, Madisonville
Doctor's Shop—Mrs. Reuben N. Lawson, Lawrenceburg
Finance—Mrs. B. T. Harris, Lexington
Heart—Mrs. Charles Rutledge, Hazard
Historian—Mrs. John S. Harter, Louisville
Legislation—Mrs. F. H. Hodges, Pikeville
McDowell House—Mrs. Walker Owens, Mt. Vernon
Mental Health—Mrs. C. Melvin Bernhard, Louisville
Nominations—Mrs. J. Andrew Bowen, Louisville
Nurse Recruitment—Mrs. Frank T. Linton, Princeton
Program—Mrs. Ed Sharman, Elizabethtown
Public Relations—Mrs. William C. Cloyd, Richmond
Rehabilitation—Mrs. C. Howe Eller, Louisville
Revisions—Mrs. R. W. Robertson, Paducah
Rural Health—Mrs. William W. Wainer, Providence
Safety—Mrs. Paul F. Zisk, Grayson
Today's Health—Mrs. Harold Keen, Bowling Green
Tuberculosis—Mrs. Duane Jones, Ashland

PAST PRESIDENTS TO THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION

*1923—Mrs. Graham Lawrence, Shelbyville
*1924—Mrs. Graham Lawrence, Shelbyville
*1925—Mrs. Van Albert Stilley, Benton
*1926—Mrs. Van Albert Stilley, Benton
*1927—Mrs. William M. Martin, Harlan
*1928—Mrs. James Thomas Reddick, Paducah
1929—Mrs. Philip E. Blackerby, Louisville
1930—Mrs. E. B. Houston, Murray
*1931—Mrs. George A. Hendon, Louisville
1932—Mrs. Arthur T. McCormack, Louisville
*1933—Mrs. Bartlett K. Menefee, Covington
*1934—Mrs. Joseph I. Greenwill, New Haven
1935—Mrs. Luther Bach, Florence
*1936—Mrs. Ernest Arthur Barnes, Albany
1937—Mrs. Stephen C. McCoy, Louisville
*1938—Mrs. Harlan Usher, Sedalia
1939—Mrs. Reasor T. Layman, Elizabethtown
1940—Mrs. John M. Blades, Butler
*1941—Mrs. John G. South, Frankfort
1942—Mrs. John B. Floyd, Richmond
1943—Mrs. Octavus Dulaney, Louisville
*1944—Mrs. Eleanor Hume Offutt, Frankfort
1945—Mrs. Shelby Carr, Richmond
1946—Mrs. Elmer L. Henderson, Louisville
1947—Mrs. Walker Owens, Mt. Vernon
1948—Mrs. R. Haynes Barr, Owensboro
1949—Mrs. Elbert W. Jackson, Paducah
1950—Mrs. Clark Bailey, Harlan
1951—Mrs. John S. Harter, Louisville
1952—Mrs. David Woolfolk Barrow, Lexington
1953—Mrs. Clyde C. Sparks, Ashland
1954—Mrs. Karl D. Winter, Louisville
1955—Mrs. R. Ward Bushart, Fulton
1956—Mrs. Charles B. Stacy, Pineville
1957—Mrs. J. Andrew Bowen, Louisville

*deceased

SPECIAL RULES OF ORDER

1. Officers and delegates are requested to sit in the assigned seats.
2. All persons appearing on the program must be seated on or near the platform when the session opens.
3. Delegates privileges are not transferable.
4. Badges must be worn by the voting body during all general sessions.
5. When addressing the chair, the speaker shall announce her name and that of her auxiliary.
6. Each speaker from the floor shall be limited to two minutes. No speaker may speak more than twice on the same question.
7. Officers giving reports shall be limited to five minutes.
8. No announcements, except those of a vital nature, shall be made from the platform.
9. All visitors are welcome at the general session.
10. All visitors and auxiliary members are requested to register.
11. The proceedings of this convention shall be governed by Roberts' Rules of Order, Revised.

BY-LAW REVISIONS

The following revisions in the Woman's Auxiliary By-Laws will be discussed at the meeting:

Article IV Standing Committees and Their Duties

Section 1. The Standing Committees of this Auxiliary consist of the following:
Number 10. Strike out Nurse Recruitment and substitute Paramedical Careers Recruitment
Number 11. Strike out Organization and substitute Membership
Number 13. Strike out Public Relations and substitute Community Service
Number 14. Strike out Revisions and substitute By-Laws.
Number 15. Strike out Today's Health (it is now a defunct committee)

Article VIII Delegates to the Annual Meeting of the American Medical Association Auxiliary

Section 1. b. Strike out one hundred and substitute 300 members (It will then read:—One representative or her alternate for each 300 members or major fraction thereof, active members in good standing in the National Auxiliary.)

Woman's Auxiliary Plans Tour During Annual Meeting

Tour of General Electric and Farmington
Lunch at General Electric
Luncheon Tickets $2.50 each

Number of Reservations .....

Address .....

Mail Reservations or Check to:
Mrs. Rex O. McMorris
408 Winton Lane Louisville 6, Ky.

Members of the Woman's Auxiliary are urged to take advantage of a tour of the General Electric Plant and the Farmington Museum which has been planned by a committee headed by Mrs. Rex McMorris, Louisville, on Thursday, September 24.

Free bus transportation, provided by W. E. (Red) Davis of the John Hancock Insurance Company, will be available and buses will leave the Brown Hotel at 11:40 for the General Electric Plant where there will be a luncheon and plant tour. On the return trip a tour of the Farmington Museum is planned. Advance reservations are urged and reservations must be picked up at the Registration Desk by noon, Wednesday, September 23.

Please clip the adjoining coupon and return to Mrs. McMorris.

New wide-use dosage form

of the outstanding
anticholinergic-antispasmodic

PRO-BANTHĪNE®
TABLETS
(HALF STRENGTH)

Pro-Banthīne (Half Strength) has been especially designed for your prescribing convenience.

This new form provides flexibility of dosage from low levels of one tablet t.i.d. for patients with minimal distress, to one or two tablets every 2 or 3 hours for those with more pronounced symptoms.

Primary indications are gastrointestinal spasm, bladder spasm, maintenance therapy of peptic ulcer and "irritable bowel" syndrome. The lower dosage also has a field of usefulness in smooth muscle spasm of children and geriatric patients.

when your prescription reads—
℞ Pro-Banthīne Tablets (Half Strength)
—the pharmacist will dispense this new size (7½ mg.)

PRO-BANTHĪNE *(brand of propantheline bromide)*

Dosage forms:
Pro-Banthīne tablets (15 mg.)
Pro-Banthīne tablets (Half Strength) (7½ mg.)
Pro-Banthīne ampuls (30 mg.)

G. D. Searle & Co., Chicago 80, Ill. *Research in the Service of Medicine.*

avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4,5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2,4,5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



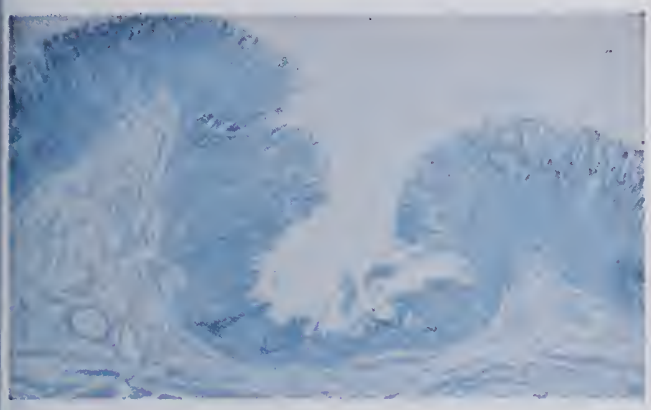
Regular aspirin crystals 24 hours after being mixed into water.



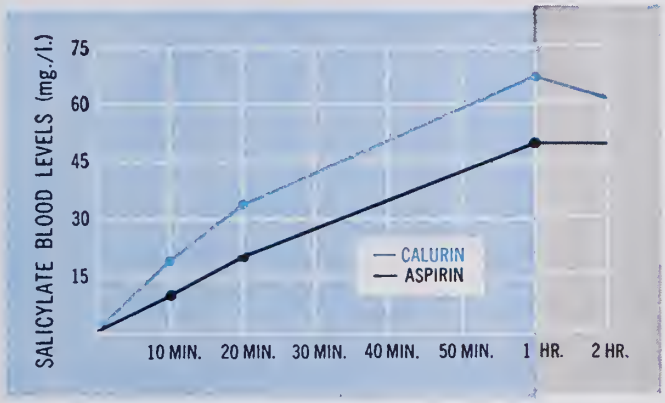
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, antipyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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SPECIAL ARTICLES

Report Of The KSMA Delegates On The Annual Meeting Of The American Medical Association

W. Vinson Pierce, M.D., Delegate

Covington, Ky.

THE 108th Annual Meeting of the American Medical Association which was held at Atlantic City, June 8-11, 1959, was considered by many to have been one of the most important in recent years, because of the significance of many of the actions which were taken there.

More than 32,000 registered at the meeting; of whom approximately 13,000 were physicians. Kentucky physicians were well represented, with more than 50 registered.

The two delegates from Kentucky, Doctor Pierce and Doctor Long, were in attendance at all of the sessions of the House of Delegates, as were George Archer, M.D., Alternate Delegate, and Karl Winter, M.D., serving as Alternate Delegate in place of Foster Coleman, M.D., who was unable to attend the meeting.

Others who attended the sessions of the House were Irvin Abell, M.D., President-elect of the KSMA, William Willard, M.D., Dean of the University of Kentucky Medical School, David Cox, M.D., M. R. Kronen, M.D., Carroll L. Witten, M.D., Mr. J. P. Sanford, Executive Secretary of the KSMA, Mr. Bobbie Grogan, Director of Field Services of the KSMA, and Mr. Harry Lehman, Executive Secretary of the Jefferson County Medical Society.

Your delegates are most grateful for the valuable assistance rendered by the alternate delegates and by others who attended various reference committee hearings and subsequently reported back to the delegates concerning the discussions which had taken place; since the delegates themselves could not be present at all of the committee meetings. In many instances these men participated in the discussions, and expressed to the committees the viewpoints of the KSMA in regard to the issues under consideration.

One of the highlights of the meeting was the appearance of President Eisenhower, who spoke to a packed auditorium of more than 5000 people, at the inauguration of the 113th AMA president, Doctor Louis Orr. This was the first time that a President of the United States had addressed an Annual Meeting of the American Medical Association. (President Eisenhower spoke at the Clinical Session in Washington, D. C., in 1953). The President's speech was also broadcast on radio and TV.

In his talk, President Eisenhower warned that inflation posed great danger to the traditional free enterprise practice of medicine, and to the ability of people who live on fixed income, such as pensions or retirement incomes, to have access to adequate medical care. He praised the medical profession for promoting better health care among our people, and especially for assuming leadership in providing a program to meet the health care needs of the aged. The medical profession, he stated, certainly wishes to provide its services at a fee or fees which people can afford to pay. No departure from the traditional policy of our physicians in this regard was implied in his remarks. Some of the newspaper comments the following day tried to make it appear that the President had taken physicians to task for overcharging; but in no sense did his remarks do this.

Mr. Eisenhower called on physicians to show our people that our economy, like our bodies, must be sound, and that "the future of our republic and of the free world depends upon our ability to maintain fiscal soundness in government, a robust economy, and a stable dollar."

Louis Orr, M.D., the new President of the AMA, proved himself a medical statesman of great wisdom, and an able spokesman for organized medicine, in his two addresses at the meeting.

In the address of the President-elect, made before the opening session of the House of Delegates, Doctor Orr emphasized four particular problem areas which

*Robert C. Long, M.D., KSMA's junior delegate to the AMA, reported on the AMA's interim session in the February, 1959 issue.

"demand full recognition and advanced planning to meet the needs of the future." These are as follows:

(1) *The costs of medical care.* Doctor Orr urged that the American Medical Association take the lead in studying this problem, and in encouraging the development of rest homes, nursing homes, home care programs, and other special facilities for patients who do not require complete hospital care. He also stressed the importance of "progressive patient care" and other new concepts in hospital administration, to make possible more efficient and economical utilization of hospital facilities and personnel.

(2) *The recruitment of qualified and dedicated young people to enter the study of medicine.*

(3) The medical profession must exert influence and leadership in seeing that the funds available for *medical research* are wisely spent.

(4) An expanding program to bring about a sound realistic approach to the *problems of aging*, and the assumption of leadership in solving these problems.

In his Presidential Address, which was given at the Inauguration ceremonies, Doctor Orr challenged the philosophies of those who value security and comfort more than freedom. He urged that we follow the road of free spirit, as dedicated men and women working together on a voluntary basis in the war against disease and illness, and stated that "we must continue to improve and broaden voluntary health programs in preference to compulsory programs that lead to waste."

Doctor Orr's speech was felt by most of those who heard it, to be one of the most excellent addresses ever made on behalf of freedom for the medical profession and for all of the people of the United States.

Gunnar Gundersen, M.D., the outgoing President of the AMA, in his address before the House of Delegates, stressed the importance of physicians charging for their services on a basis which permits the insurance industry to sell health insurance at a price which people can afford. He gave high praise to our Blue Shield Plans for having responded so promptly and ably in developing programs for the care of people past 65, in the past few months.

Doctor Gundersen strongly urged that all physicians "keep abreast" of the new developments in medicine, and stated that any physician who fails to do this blackens the eye of American Medicine as much as the person who overcharges.

Actions of the House of Delegates

Many important actions and policy decisions were made by the House of Delegates at this meeting. To attempt to do full justice to all of them would be impracticable. Some of the more important ones will be discussed briefly.

The Report of the Commission on Medical Care Plans unquestionably attracted the greatest interest of any of the items on the agenda. Dr. John S. DeTar, former president of the Academy of General Practice, headed the special reference committee to consider this report. The personnel of Dr. DeTar's committee was the same as that at the last Clinical Session, when the committee had so wisely recommended that action on the report be deferred for further study.

The hearing at this session was a spirited and prolonged one, at which numerous delegates spoke, and at which many expressed their opposition to some of the statements contained in the body of the Commission Report. Dr. Robert Long, Delegate from Kentucky, and Dr. George Archer, Alternate Delegate from Kentucky, effectively and forcefully expressed the viewpoint of the KSMA in regard to these closed panel systems of practice which deny their participants the right of free choice of physicians. The emotional pitch of the discussion reached a climax when Dr. Warren Draper stated flatly that "the Plan of today is what Dr. Draper says it is!"

When the reference committee reported to the House, it was immediately voted to accept Part I of the Commission Report "as information only," which means that statements contained in 91 pages of the Report cannot be lifted out of context and quoted as the official position of the American Medical Association. The House adopted thirty-six of the recommendations of the Commission without change, but reworded three topics which related to Miscellaneous and Unclassified Plans.

In regard to the question of free choice of physician, the reference committee report pointed out that a study of the replies to the questionaires which had been sent to all of the constituent medical associations, showed that segments of the medical profession have accepted deviations in the application of the "free choice" principle in some forms of medical practice which involve large numbers of people.

All who testified before the reference committee stated that free choice of physician should be supported in principle, but most agreed that there are certain exceptions in applying the principle.

The following statements in regard to free choice of physician were among those adopted by the House:

"The American Medical Association believes that free choice of physicians is the right of every individual, and one which he should be free to exercise as he chooses. Every individual should be accorded the privilege to select and change his physician at will, or to select his preferred system of medical care; and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

"Free choice of physicians is an important factor in the provision of good medical care. In order that the principle of free choice of physician be maintained and fully implemented, the medical profession should discharge more vigorously its self imposed responsibility for assuring the competency of physicians services and their provision at a cost which people can afford."

The House also strongly endorsed Recommendation B-11 of the Commission Report, which declared that "those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

In regard to physicians participation in medical care plans, the House acknowledged a Commission conclusion that there is no generally held opinion declaring that participation in closed panel medical care plans would render a physician unethical. It was pointed out by the reference committee that in reply to the questionaire which had been sent out regarding this problem, eighteen constituent associations indicated that physician participation was acceptable, nine indicated that such association was unacceptable, and thirteen either gave other answers or qualified their answers.

The House adopted without change a recommendation of the Commission that medical profession sponsored plans such as Blue Shield should seek to extend their coverage as a deterrent to the future development of closed panel plans.

As was stated in the "AMA" News for June 29th, the AMA through the recent actions of the House of Delegates, has now officially taken the position that physician participation in medical care plans, including those operated by unions, is not necessarily unethical.

Medicine and Osteopathy

The special report of the Judicial Council regarding Osteopathy was referred to the reference committee on Constitution and By-laws. There was prolonged discussion of this report at the reference committee hearing.

The official AMA position, as adopted by the House, is as follows:

(1) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles is unethical.

(2) Enactments of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations, and graduate from schools approved by the same agency, should be encouraged by the constituent associations.

(3) It shall not be considered contrary to the principles of medical ethics for doctors of medicine to teach students in an osteopathic college which is in the process of converting into an approved medical school under the supervision of the AMA Council on Medical Education and Hospitals.

(4) A liaison committee is to be appointed by the Board of Trustees of the AMA to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern, including interprofessional relationships at a national level.

The American Osteopathic Association was commended for amending its constitution so as to emphasize scientific objectives and high standards of medical education.

The House also recommended that the AMA representatives on the Joint Commission for the Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider the accreditation of those hospitals required by law to admit osteopathic physicians to their staff.

Social Security

Three large delegations, at the direction of their respective state associations, those from Pennsylvania, New York, and New Jersey, introduced resolutions favoring compulsory inclusion of self-employed physicians under the provisions of Social Security. The delegation from Virginia introduced a resolution requesting continued study of the question. The delegates from Georgia brought a resolution opposing compulsory inclusion for physicians.

In considering this subject, the reference committee on Legislation and Public Relations presented the following information:

(1) The United States Supreme Court has held that Social Security is not an insurance program.

(2) Social Security is basically a tax program, and the tax payer has no vested right in the benefits.

(3) Under Social Security there is no contract between the individual and the government.

(4) Under Social Security the tax rate and the benefit structure may be changed at any time by legislative action, whereas an insurance contract has a fixed premium and a fixed benefit to be paid at a specified time.

The committee also stated that only 4% of the physicians in the United States are retired, and hence that most physicians would not be eligible for Social Security benefits until they are 72 years of age.

In speaking before the reference committee, many physicians urged that consideration be given to the possible effects that a change of Association policy in this regard might have on the entire legislative program of the American Medical Association, especially in regard to the Association's stand on HR 4700 (The Forand Bill).

By a large majority, the House voted to continue in opposition to compulsory Social Security for Physicians.

A resolution was adopted that the AMA continue to expand its educational program to inform its members of the economic, social, and moral advantages of economic security obtained under the free enterprise system rather than through the mechanism of governmental Social Security. The Board of Trustees was requested to investigate the possibility of developing group insurance and retirement plans which could be made available to AMA members.

Preparation for General Practice

The House approved the report of the Committee on Preparation for General Practice, which recommended a period of at least two years of hospital training after graduation from medical school, in preparation for family practice. It was recommended that the new program should include:

(1) A basic minimum of 18 months in-hospital training to include the pediatric, diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine.

(2) Regularly assigned periods of emergency room service and training in minor surgery.
(3) Adequate opportunity for study of outpatients.
(4) Training in obstetrics to be part of a six month additional elective period; but not mandatory for those who do not anticipate an obstetrical practice.

It was urged that the two-year program be planned and implemented as a unified whole, with a maximum continuity of assignment in specific services.

Other Actions of the House

The House approved a recommendation that "Today's Health" and one of the specialty journals which is published by the AMA be included as a benefit to dues paying members, in addition to the Journal of the American Medical Association and the "AMA News," which are now being sent to all members.

The Board of Trustees was requested to study the advisability of establishing a loan or scholarship fund for worthy and needy medical students, and to decide upon the proper criteria for determining the eligibility of the applicants.

It was recommended by the House that state medical associations initiate and sponsor legislative activities to eliminate cancer quackery.

State and county hospital associations and medical societies were urged to assist in the establishment of hospital medico-legal and education committees to study the problems of preventing and dealing with damage suits against hospitals and hospital personnel.

The problems arising concerning the relation of medicine to optometry were considered, and the House voted to establish a sub-committee, under the "Committee to study medical and allied professions and services" which sub-committee would study specifically the relation of medicine to optometry, and provide consultation services on the problem.

All members of the American Medical Association were urged to support the American Medical Education Foundation with generous gifts.

Officers and Meetings

Vincent Askey, M.D., of California, was named the new President-elect. He was elected over George Lull, M.D., former General Manager and Secretary of the AMA by a vote of 122-81. Dr. Askey has been Speaker of the House of Delegates of the AMA for the past few years, and prior to that had served as Vice-Speaker of the House. He has held many important offices in the California State Medical Association. He is a practicing surgeon in Los Angeles, and is a Diplomate of the American Board of Surgery, as well as a Fellow of the American College of Surgeons. With Doctor Orr as the new President, and Doctor Askey as President-elect, the A.M.A. is assured of a very high quality of leadership in the next two years.

Norman Welch, M.D., of Boston was elected the new Speaker of the House, and Milford Rouse, M.D., of Dallas, the Vice-speaker. Doctor Rouse is well known to many Kentucky doctors, as he is just completing a term as President of the Southern Medical Association.

R. B. Robbins, M.D., of Arkansas, and Hugh Hussey, M.D., of Washington, D. C., were re-elected as Trustees for 5-year terms. Percy Hopkins, M.D., of Chicago, Ill. was elected as a Trustee to fill the unexpired term of Dr. Furey, who died last year.

Chicago was chosen as the meeting place for the 1962 Annual Meeting. It had previously been determined that Miami will be the site of the 1960 Annual Meeting, and New York, in 1961.

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EDITORIALS

Our Annual Session

WHETHER right or wrong the Council of the Kentucky State Medical Association nine years ago decided to conduct the annual sessions of our society in Louisville because it is the most centrally located city in Kentucky, and because it is able to provide more ample accommodations for those desiring to attend. The wisdom of this decision seems to be established by the increasing attendance and interest which has been manifest from year to year. It is therefore probable that this plan will be continued. With the central office of the Association located here it is more convenient to conduct the Annual Meeting without completely disrupting and moving the personnel and files to another city.

The president and his staff of elected officers with the help of the central office personnel have a year round task in providing for the annual meeting. It is hoped that none among us fail to appreciate the devotion and foresight and work that goes into this preparation. The physicians of Louisville consider it a privilege to be hosts to our Association. We trust that there is no reason to believe that our spirit of hospitality grows thin or that our resources of entertainment deminish from year to year.

The increased financial resources of the Association have made possible the expansion and improvement in the character of our scientific programs during the past ten years. Inauguration of the half day program for the Specialty Groups with their invited visiting speaker, and the policy of using these distinguished physicians also for the general program and panel discussions has, we think, considerably improved the value and appeal to the members. The committee on scientific exhibits has sought to present new material of more general interest.

Of no little value to the visiting physicians are our commercial exhibits. Selected exhibitors present the latest and best in medications, methods, instruments, equipment, books, and periodicals. These are the same exhibitors who will be found at the best of our national meetings. They render us a service of very great practical value. The modest stipend they pay for this opportunity helps greatly to defray the incidental expenses of the meeting.

The main business of our Society is transacted through the meeting of the Council and the House of Delegates at the Annual Session. This function has become increasingly important as the socio-economic problems of medicine have pressed upon us for solution during the past two decades. We can scarcely appreciate the time and effort that is expended during the year by the members of the council in directing the affairs of our Society. Their important deliberations and decisions are submitted annually to the House of Delegates for open discussion and decision as to policy. It is the privilege of any member to attend these meetings of the House of Delegates and to appear before the Reference Committees to present such constructive thoughts as he may have toward the proper conduct of our affairs. If we neglect to exercise this opportunity which is afforded freely at every Annual Meeting, we have little ground to criticize the action that is taken by those who do vitally interest themselves in these important matters.

No physician should come to the annual meeting without inviting and urging his wife to accompany him. The affairs of the auxiliary have been increasingly important and of interest to the doctor and his whole family. More wives should be encouraged to participate in this constructive program which has in recent years become our strong right arm and our best instrument of public relations. Beside this there are dinners, tours, golf, and other forms of entertainment and recreation which the local phy-

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

sicians' wives are delighted to extend to our guests.

Louisville has some challenging golf courses. Some are old and familiar and you will enjoy playing them again. Some are entirely new; if you have never played them you have a new thrill in store for you. A golf tournament is provided for those enjoying competitive play. Too few physicians have participated in this tournament in recent years. Before you start from home, throw your golf clubs in the back of the car—and your wife's too, for that matter; enjoy a little recreation while you are here. It would be stale to devote four days entirely to business and the pursuit of scientific knowledge.

The Medical School in recent years has staggered its schedule of class reunions so that a number are held during the State Meeting instead of at commencement time. Find out whether your class is to hold a reunion at this session, and plan by all means to attend. If not, there is always the opportunity to extend your professional acquaintances to those from other parts of the State in less formal manner.

If the above incentives do not appeal to you, find some others that do. At any rate, tear yourself away from your work and responsibility for a few days; take a little breather and a little rest at the annual meeting in September. Louisville's door of hospitality is open and we will hope and expect to see you.

Sam A. Overstreet, M.D.

The Ever-Changing Social Security System

SOCIAL Security is not insurance; it is a compulsory tax for public charity.

In 1935 the law was passed entitled "Federal Old-Age Benefits." As soon as the Supreme Court upheld the tax and welfare program in 1937, the administrators began a propaganda campaign to make people believe their system is insurance.

Two years later, in 1939, the original law was scuttled and a whole new system was enacted with the title "Old-Age and Survivors Insurance Benefits." Some extension of the system has been passed every two or four years since.

People feel that the money deducted from their salary is for their own benefit; but that money is used long before they draw benefits. Your children and their children will be paying for your handout.

When the government tells a citizen, "you are being taxed to provide an income for yourself or your family," the statement is categorically and purposefully false. The citizen, in fact, is being taxed to provide an income for somebody else, a stranger and for a family of strangers.

There is no insurance contract. Congress has the power to alter, amend, or repeal. That power leaves the citizen no legal right to any benefits.

If not legal rights, what about moral rights? Surely our government will respect them. So one would like to think. But, the fact is, they have not been respected, but have been dishonored time and again.

The first Social Security Act promised the people "permanent" coverage if they paid taxes for five years. In 1939 this was raised to ten years.

The act of 1935 guaranteed every person brought under the Social Security Act at least his money back. The Congress took this away in 1939 and in the 15 years that followed, 6,400,000 died without getting either pensions or refunds for themselves or their families.

During the 1940's thousands of people 65 years of age retired and started drawing Social Security benefits, then started little businesses of their own.

The 1950 Congress extended Social Security coverage to self-employed. In one year 22,208 were stripped of their pensions and forced to pay "contributions" out of their earnings "to build up security for their old age."

The government broke faith, but it did not break it's contract. There is no contract.

The Social Security experiment is the most colossal gamble with the peoples money undertaken by any government in human history. It began as a device to enforce thrift upon those who work for others. Now after 24 years, 19 out of every 20 workers are paying Social Security taxes.

David Cox, M.D.

Salute To A Veteran

F. P. THOMAS, M.D., of Hopkinsville, graduated from Louisville Medical College in 1894 and has practiced in his native town since that year except for his period of service in World War I. He occupied the same office in 1894 until 1957 when he fell and broke his hip; he thereafter maintained his office in his home. He has not felt it necessary to display his name on his office door at any time during this period. He has conducted himself in such manner as to maintain the highest respect of his colleagues and fellow citizens for himself and entire family.

Doctor Thomas has an exceptional record in that he has paid AMA dues regularly from 1894 until 1959. We try ourselves and exhort our colleagues to moral and financial support of our parent medical association and of adherence to its principles. Few physicians in the United States can match Dr. Thomas' period of unbroken and faithful service in this regard.

That a physician should retire from practice at the age of 86 is no particular item of news, but that he should have maintained so long and so consistent a record of faithfulness and service should evoke a tribute from his younger colleagues. It must be pleasing to him as he enters retirement to feel that he has "run a good race and kept the faith." We salute him.

Sam A. Overstreet, M.D.

Hear . . .

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(Health and Medical)

at the

President's Luncheon

Crystal Ballroom—Brown Hotel

Wednesday, Sept. 23

day and night—ulcer control with **B.I.D.** *dosage*



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ORGANIZATION SECTION

Dr. Crume, KSMA Councilor, Dies in Bardstown at 53



William Keith Crume, M.D., Bardstown, who had served the KSMA as Fourth District Councilor for the past six years, died unexpectedly of a heart attack at Flaget Memorial Hospital on July 10.

He was admitted to the hospital that morning following a heart attack at his home. He had suffered a previous attack about three months ago, but was recovering and had planned to resume his practice on August 1.

It was through his efforts and those of Monsignor James H. Willett that the Flaget Memorial Hospital was built. He had been an officer of the hospital since its founding and served as its second staff president.

Interested in civic affairs, Doctor Crume was a member of the Bardstown City Council for two terms and was in office when he died and was also a member of the Bardstown Board of Education and the Nelson County Health Department. He was a director of the Farmers Bank and Trust Company and a member of the Optimist Club.

Doctor Crume was born on December 21, 1905. He graduated from the Louisville College of Pharmacy in 1926 and from the University of Louisville School of Medicine in 1934. He interned at Louisville General Hospital.

Commenting on Doctor Crume's death, Robert W. Robertson, M.D., KSMA president said, "His service, wisdom, and guidance will be missed by the Council of the Association on which he has served so faithfully for the past six years."

Members Urged to Register Before September 5

If you failed to register for the May state primary elections, but would like to vote in the November 3 general election, you have until September 5 to register.

You should register if you haven't exercised your voting privilege in the past two years or if you have not previously registered. You are eligible to register if you have been a resident of Kentucky for 1 year, or more, have lived in your county 6 months and in your precinct 60 days.

All KSMA members were urged to take advantage of their voting privilege and to register before the deadline by Wyatt Norvell, M.D., New Castle, chairman and Thomas Leonard, M.D., Frankfort, vice chairman of the KSMA Legislative Committee for State affairs.

New Yorker to Address Meeting of Sixth District, Aug. 27

"Legal Medicine" will be the topic discussed by Coleman Taylor of Amsterdam, N. Y., at the meeting of the KSMA's Sixth Councilor District at the Olde Forte Restaurant, Bowling Green, on Thursday, August 27.

Announcement of the meeting was made by J. P. Glenn, M.D., Russelville, District Councilor, who will also make brief remarks at the meeting. Local arrangements are being made by Benjamin H. Todd, M.D., Bowling Green. Host group will be the Warren-Edmonson-Butler County Medical Society.

The meeting will start with a social hour at 7 p.m. followed by dinner. Rex Hayes, M.D., Glasgow, District president, will preside. Waller H. Griffing, M.D., Bowling Green, is District secretary.

Dr. Harvey Receives Appointment from President Eisenhower

President Dwight D. Eisenhower recently appointed Daryl P. Harvey, M.D., Glasgow, as a member of the President's Citizens Advisory Committee on the Fitness of American Youth.



The committee serves in an advisory capacity to the Council on Youth Fitness and considers and evaluates "existing and prospective governmental and private measures conducive to the achievement of a happier, healthier, and more completely fit American Youth." Membership in the committee is appointed from all sections of the nation.

Other physicians serving on the committee include: Paul Dudley White, M.D., Boston cardiologist; Lewis Bauer, former president of the AMA and secretary-general of the World Medical Association, and William Walsh, M.D., who is heading up the people-to-people program sponsored by the Federal government.

This is the second Presidential appointment Doctor Harvey has received within a year. Last summer he was appointed a vice-chairman of the 1960 White House Conference on Children and Youth. Doctor Harvey is president of the Kentucky Academy of General Practice.

Dr. Orr to Speak in Lexington on September 1

Louis M. Orr, M.D., president of the AMA, will address a joint meeting of Lexington civic clubs at the Student Union Building, Lexington on September 1.

Doctor Orr will discuss an amendment to the Social Security Act now pending in Congress. The amendment would place certain persons in line for insurance for hospital, nursing home, and surgical costs.

He has spoken at two KSMA functions—Senior Day in 1958 and the County Society Officers Conference in 1955.

U of L Hosps. Honor Alumnus

R. Glen Spurling, M.D., was named distinguished alumnus by the University of Louisville Hospitals Alumni Association during the Association's sixth annual Alumni Day June 19. He is the first alumnus to receive the honor. James Bruce, M.D., Louisville, was named president-elect. W. O. Johnson, M.D., Louisville, became president, succeeding Alvin B. Ortner, M.D., Louisville.



KSMA Delegates to the AMA, W. Vinson Pierce, M.D., and Robert C. Long, M.D., check the AMA DAILY BULLETIN during an intermission of the third meeting of the AMA House of Delegates on June 11, at Atlantic City, New Jersey.

7th Dist. Elects Officers at Meet in Frankfort June 25

Hugh C. Williams, M.D., Carrollton, was elected president of the Seventh Councilor District, to succeed H. V. Stewart, M.D., Carrollton, at a meeting of the District in Frankfort on June 25.

Results of the election of officers were released by Wyatt Norvell, M.D., New Castle, District councilor. Others elected were: John H. Leland, M.D., Crestwood, and Joseph H. Leibman, M.D., Frankfort. Fifty-five physicians attended the meeting.

Featured on the program were: R. W. Robertson, M.D., Paducah, KSMA president; E. Gaines Davis, Frankfort, KSMA legal counsel; E. S. Weaver, M.D., Carrollton; and Livingston A. Wahle, M.D., Shelbyville. T. P. Leonard, M.D., Frankfort, president of the Franklin County Medical Society, welcomed the physicians to the meeting.

Dr. Griswold to Speak Sept. 28 to College of Surgeons

R. Arnold Griswold, M.D., Louisville, will give one of the major addresses at the 45th annual Clinical Congress of the American College of Surgeons in Atlantic City, New Jersey, September 28-October 2.

More than 10,000 Fellows of the College and guests from all over the world will gather to participate in nine postgraduate courses, panel discussions, symposia, motion pictures, color television, and cine clinics.

Newell W. Philpott, M.D., Montreal, current president of the College will preside at the opening session of the meeting. On October 2, the last day of the meeting, initiates will be presented for Fellowship, honorary Fellowships conferred and officers inaugurated.

Southern Medical Announces Plans for 53rd Annual Meeting

The Southern Medical Association has announced that its 53rd Annual Meeting will be held in Atlanta, Ga., at the Atlanta Municipal Auditorium on November 16, 17, 18, and 19.

Symposia on nuclear medicine and geriatrics will be highlights of the four-day meeting which will have the usual scientific lectures, panel discussions, exhibits, sectional programs, and medical color television.

The Woman's Auxiliary of the Association will hold its meeting simultaneously at the Henry Grady Hotel. A feature of their program will be a Doctors' Day Auxiliary Awards Luncheon to which husbands are invited.

Clinics for Handicapped Children Set by Commission

Physicians are invited to refer patients and to attend clinics offered by the Kentucky Crippled Children Commission, the official state agency serving children handicapped by orthopedic conditions, cleft lip and palate, organic speech defects, or needing plastic surgery.

An initial diagnostic examination is available to all children, but services are given only to those who are medically indigent. Appointments for patients should be made in advance at Kentucky Crippled Children Commission, 1405 East Burnett Avenue, Louisville, or Kentucky Crippled Children Commission, c/o Cardinal Hill Convalescent Hospital, Versailles Rd., Lexington.

Following is a schedule of clinics scheduled for the remainder of August:

Louisville—Kosair Crippled Children Hospital—
8:30 to 11:30

Thursday, August 20	Orthopedic Clinic
Friday (PM) August 21	Scoliosis Clinic (by referral from orthopedic clinic)
Thursday, August 27	Orthopedic Clinic
Friday, August 28	Orthopedic Clinic

Lexington—Out-Patient Department—
Cardinal Hill Convalescent Hospital

Thursday, August 20	Plastic, Cleft Palate
Friday, August 21	Orthopedic
Wednesday, August 26	Cerebral Palsy
Friday, August 28	Orthopedic

Covington—Treatment Center

Wednesday, August 26	Cerebral Palsy Clinic

Ashland—King's Daughters Hospital

Tuesday, August 25	Orthopedic

Princeton—Westside School

Tuesday, August 18	Orthopedic

Drs. Beard, Ritterhoff Appointed

Marion Beard, M.D., Louisville, and R. J. Ritterhoff, M.D., Covington, have been appointed to represent the KSMA on the North Central District Blood Bank Clearing House. Doctor Beard, who is chairman of the KSMA's Blood Bank Committee, was appointed a voting member of the Board representing the committee. His term is for three years. Doctor Ritterhoff was reappointed an advisory member of the Board for a one-year term ending June 30, 1960.

Watch for

Forand Testimony in Sept. Journal

KSMA testimony before the House Ways and Means Committee on the Forand Bill (HR4700) will appear in the September issue of the Journal. The testimony which was given by Carl Fortune, M.D., Lexington, representing the Association, will be in the form of a "Special Article."

Mr. Blackerby, Barr Award Winner Dies in Louisville

James F. Blackerby, Louisville, first winner of the KSMA's R. Haynes Barr Award and former director of the Bureau of Vital Statistics and Records for the State Department of Health, died on June 30 at his home. He was 82.



Born in Berlin, Bracken County, Mr. Blackerby was the son of P. N. Blackerby, M.D. He graduated from the Louisville College of Pharmacy in 1893 and was in the drug business for 23 years. He started his work with the Health Department in 1921 when he succeeded his brother P. E. Blackerby, M.D., as director of vital statistics. Mr. Blackerby retired from this post in July, 1958, but had served as a consultant up until his death. His son, James Blackerby, M.D., practices in Stanford.

Dr. Scroggin Heads Sportsmen

Fred R. Scroggin, M.D., Williamstown, was recently elected president of the League of Kentucky Sportsmen. He is past president of the Fifth District Federation of Kentucky Sportsmen. Doctor Scroggin was elected at a 3-day annual meeting in Lexington which was attended by approximately 200 sportsmen club representatives.

PAWMA Sets Date for Congress

The Pan American Woman's Medical Alliance has set the date of its next Congress as June 2-7, 1960 in Puerto Rico.

In extending the invitation to the Alliance to hold its annual session in Puerto Rico, the president of the Puerto Rico chapter of the alliance said, "We are quite sure that all members of the PAMWA will enjoy a trip to Puerto Rico. The exceptional beauty of our countryside, our excellent year-round climate, glittering beaches, cool mountains, modern hotels, and historical surroundings will contribute greatly to your entertainment."



Pictured at the July 2 meeting of the Second Councilor District at the Henderson Country Club are—(left to right)—Walter L. O'Nan, M.D., Henderson, District councilor; Harry Becker, M.D., Indianapolis, guest speaker; Robert W. Robertson, M.D., Paducah, KSMA president; Robert English, M.D., Henderson; and William C. Hambley, M.D., Pikeville.

Tennessee Valley Meet, Sept. 28-9

The Tennessee Valley Medical Assembly, sponsored by the Chattanooga and Hamilton County Medical Society, will be held at Read House, Chattanooga, Tenn., on Sept. 28-29.

Featured speaker at the banquet on Monday night, September 28, will be Morris Fishbein, M.D., medical editor of Encyclopedia Brittanica, who will speak on "Medicine and the Changing Social Order." Early registration for the meeting is urged. Registration fee is $15. Send registration to: Chattanooga Convention and Visitors Bureau, 819 Broad St., Chattanooga, Tenn.

Named to AMA Committee

J. P. Sanford, executive secretary of the KSMA, was recently appointed to serve on a committee of medical society executives which serves in an advisory capacity to the director of the American Medical Association's Communications Division by the AMA's Board of Trustees. His appointment to the nine-man committee is for a three-year term. The committee meets four times a year to go over plans for the public relations activities of the American Medical Association. Announcement of Sanford's appointment was made by F. J. L. Blasingame, M.D., Chicago, AMA executive vice president.

Anesthesiologists Meet in Dayton

Kentucky physicians are invited to attend the meeting of Ohio Society of Anesthesiologists at Dayton Ohio on Saturday, September 19. The day-long meeting will start with registration at 8:30 a.m., and will include 12 scientific presentations, and a panel discussion.

Ohio GP's Plan Annual Assembly

The ninth annual Scientific Assembly of the Ohio Academy of General Practice will be held at the Veterans Memorial Building in Columbus, Ohio, on September 16-17, 1959. The meeting is acceptable for 10 hours of Category 1 credit for AACP members.

Committee Reports

Constitution and By-Laws Committee

Cooley L. Combs, M.D., Hazard, Chairman

Louisville **June 25**

The committee spent an afternoon-long meeting compiling its report for the House of Delegates.

Blue Shield Commission

W. Vinson Pierce, M.D., Covington, Chairman

Louisville **July 2**

Guest speakers at the Commission meeting included Ira C. Layton, M.D., Kansas City, officer of the Kansas Blue Shield Plan, and Richard Nelson of the AMA Headquarters Office. Dr. Layton spoke on the advantages of full payment plans and Mr. Nelson talked on the developments in the various states for the provision of special coverage for the aged. The Commission completed the draft of its report to the Council.

Not counting military personnel or civilians in mental or other long-term institutions, the American people had, all told, about 24 million impairments during the 12 months from July, 1957 through June, 1958. The impairments included chronic or permanent defects as paralysis, deformity, and total or partial loss of hearing and vision, according to reports issued by the U.S. National Health Survey of the Public Health Service. The rate of impairments during the 12-month period was 141.4 per 1,000 persons in the civilian, non-institutional population.



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In Memoriam

JOHN S. BRALLIAR, M.D.
Franklin
1905-1959

John S. Bralliar, M.D., died of a heart attack while sleeping on Saturday, July 11. He had practiced in Franklin and Simpson Counties since 1946.

Doctor Bralliar graduated from the University of Tennessee College of Medicine in 1939. At one time he practiced in Tennessee and in Arizona. During World War II he was in the Army Medical Corps.

EDWARD J. KEEN, M.D.
Bowling Green
1871-1959

Edward J. Keen, M.D., who had served as a physician in Warren and Allen counties for more than 50 years, died on June 25 at the age of 88 following a long illness.

A native of Allen county he taught school and practiced medicine there before moving to Warren County. He practiced at Woodburn for 23 years before beginning 25 years of practice in Bowling Green. One of his sons, Harold Keen, M.D., practices in Bowling Green.

E. LEE HEFLIN, M.D.
Louisville
1875-1959

E. Lee Heflin, M.D., a general practitioner in Louisville for 60 years, died at Kentucky Baptist Hospital after a long illness on June 19. He was a native of Fleming County.

A past president of the Jefferson County Medical Society and a past vice president of the KSMA, Doctor Heflin was a graduate of the Jefferson Medical College in Philadelphia in 1897. He started practice in Louisville after his graduation and had continued until his retirement a year ago. Doctor Heflin was awarded an honorary doctorate from the U of L several years ago.

VIRGIL LOVELACE, M.D.
Lovelaceville
1881-1959

Virgil Lovelace, M.D., retired Ballard County physician died on June 11 at St. Frances Hospital in Cape Girardeau, Mo., where he had moved on his retirement 15 years ago.

Doctor Lovelace had practiced in Ballard county for many years and was well known throughout Western Kentucky. He moved to Cape Girardeau from Fulton County.

WILLIAM DEWEY OSBORNE, M.D.
Bypro
1898-1959

William Dewey Osborne, M.D., died on June 22 at St. Josephy Infirmary in Louisville. He had been ill with a heart ailment.

Doctor Osborne, a 1924 graduate of the University of Louisville School of Medicine, had practiced medicine in Floyd County for 35 years. For many years he was a member of the Floyd County Board of Education.

News Items

Rex L. Huff, M.D., has moved from Seattle, Washington, to Elizabethtown where he will limit his practice to internal medicine. Doctor Huff graduated from Indiana University School of Medicine in 1944 and interned at Indianapolis General Hospital. He served as a Captain assigned to the U. S. Army Manhattan Project.

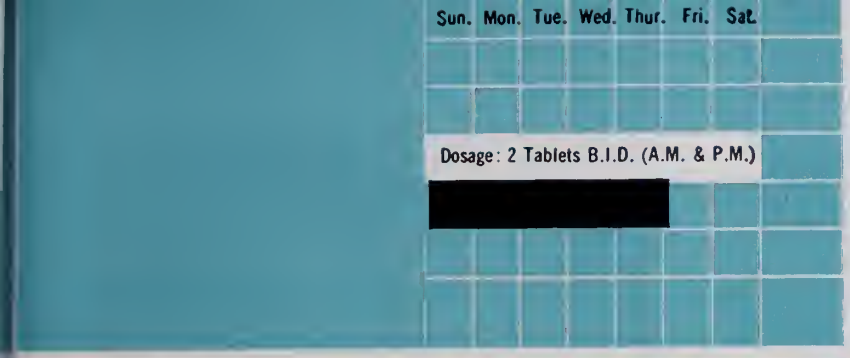
William F. Ruoff, M.D., has become associated with the Fuller-Morgan Clinic in Mayfield where he will limit his practice to internal medicine. A graduate of the University of Indiana School of Medicine in 1952, Doctor Ruoff interned at Milwaukee County General Hospital in 1953 and took his residency training at VA Hospital and Louisville General Hospital. He served as a Captain in the U. S. Army Infantry from 1942-6.

George M. Gumbert, Jr., M.D., a native of Richmond, has opened an office in Lexington for the practice of orthopedic surgery. Doctor Gumbert graduated from the University of Louisville School of Medicine in 1953, interned at District of Columbia General Hospital in Washington and took his residency training in Lexington, from 1955-59. He was in general practice in Olive Hill from 1954-5.

Edward C. Graves, M.D., has started the practice of urology in Louisville. Doctor Graves graduated from the University of Louisville School of Medicine in 1953 and interned at General Hospital. He took his residency training in general surgery at the University of Michigan Hospital, Ann Arbor, and in urology at the University of Kansas Medical Center, Kansas City, Kansas, from 1956-59.

William H. Gillespie, M.D., a graduate of the University of Louisville School of Medicine in 1955, has opened an office in Louisville where he will limit his practice to dermatology. Doctor Gillespie interned and took his residency training at the University of Clinics. He was a Lt.(jg) in the U. S. Navy from 1948-9.

Allen Winchester, M.D., a 1958 graduate of the University of Louisville School of Medicine, has started the general practice of medicine at Whitley City. A native of Stearns, he interned at the Medical Center, Columbus, Ga.



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NEWS ITEMS

Ahmad Hatam, M.D., resident in radiology at the University of Louisville School of Medicine, has been named a fellow in radiological research of the James Picker Foundation. A native of Iran, Doctor Hatam received his M.D. degree from the University of Geneva, Switzerland, in 1952. He has been a resident in Louisville since 1956. The Picker Foundation to foster X-ray research announced awards to 16 physicians nationally amounting to a total of $70,000.

E. Fred Smock, Jr., M.D., has started the general practice of medicine in Buechel in association with **Richard Slucher, M.D.,** and **James Linville, M.D.** A 1958 graduate of the University of Louisville School of Medicine, Doctor Smock interned at St. Joseph Infirmary. He was in the U.S. Army Medical Corps from 1944-6. He is a native of Louisville.

Theodore Adam Schramm, M.D., a 1953 graduate of the University of Louisville School of Medicine, has opened an office in the Medical Arts Building, Louisville, where he will limit his practice to psychiatry. Born in the Bronx, New York, he interned at Louisville General Hospital and took residency training in psychiatry at Louisville General (1954-5), Central State Hospital, (1955-6); Norton Memorial Infirmary (1956-7); and Child Guidance Clinic. He was staff psychiatrist at Central State Hospital from July to September of 1957.

Harold W. Conran, M.D., a native of Newfoundland, Canada, has joined the staff of Western State Hospital, Hopkinsville, where he will serve as a neurologist and psychiatrist. He is a graduate of Queen's University Medical School in Kingston, Ontario, in 1939, and interned at Ontario Hospital in Kingston. He had three years of residency training at Ontario Hospitals in Hamilton and Kingston. From 1953-4 he studied Neurology and Psychiatry at the University of Durham, Newcastle-on-Tyne, England, and National Hospital for Nervous Diseases, London.

Steve C. Cuff, M.D., has started the practice of pediatrics in Bowling Green. Doctor Cuff, a native of Nashville, Tenn., graduated from the University of Louisville School of Medicine in 1954. He interned at Louisville General Hospital from 1954-55. From 1955-57 he was senior assistant surgeon at the U.S. Public Health Service Communicable Disease Center. Following that he completed his residency training at Children's Hospital, Louisville.

J. F. Harrell, M.D., former director of the Carlisle County Health Department, who has been ill for some time, has moved to Little Rock, Arkansas.

Hobart Lester, M.D., Louisa, accepted a fellowship in anesthesia at the Cleveland Clinic, Cleveland, Ohio, and took over his new duties on July 1. A graduate of the University of Louisville School in 1946, he interned at St. Mary's Hospital, Huntington, W. Va. He has practiced in Louisa since 1947, with the exception of two years that he spent in the U.S. Air Force.

George F. Brown, M.D., a graduate of Tulane University Medical School in 1952, is practicing obstetrics and gynecology in Bowling Green. He interned at Philadelphia General Hospital and took his residency training at University Hospital, Little Rock, Ark., and St. Vicent's Hospital in Indianapolis. He was in the Army Air Force in 1943-5.

Irvin Abell, Jr., M.D., president-elect of the KSMA, was one of five Kentucky health leaders named members of a professional committee to select the State's 15 winners of the National Foundation's 1959 Health Scholarships.

Melvin V. Wicker, M.D., Wayland, who has served 48 years as a physician in Floyd County was named a member of the Floyd County Hall of Fame. The honor was awarded at the fourth annual meeting of the Hall of Fame in Prestonsburg on June 13. He was cited for "his devoted duty to his mountain people, for his many kind deeds to his fellowmen, and for the example he has set as a devoted husband, father, and exemplary citizen."

Alvin C. Rolen, M.D., a native of Birmingham, Ala., has started practice in Murray. Doctor Rolen is a graduate of the University of Tennessee in 1958. He took his internship at Mid-state Baptist Hospital.

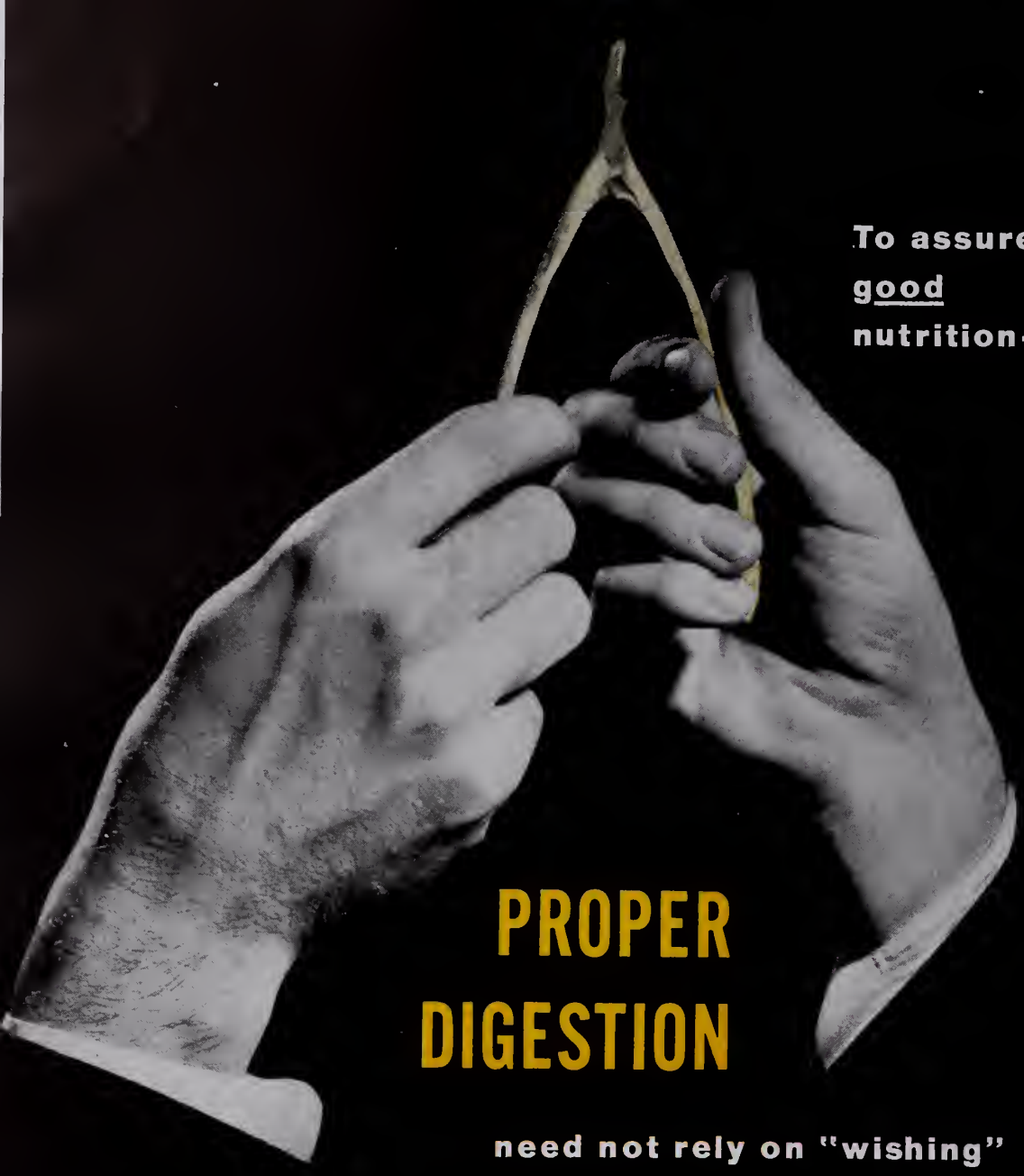
Edward H. Ray, Jr., M.D., a graduate of Tulane University School of Medicine in 1953, has started the practice of urology in Lexington. Doctor Ray interned at Charity Hospital, New Orleans, in 1953-4 and took his residency training at Tulane Service Charity Hospital, from 1954-7. He served in the U. S. Navy as chief of urology, U. S. Naval Hospital, Newport, Rhode Island, with the rank of Lt. senior grade.

F. M. Sherman, M.D., Owensboro, received a gold pin for 50 years of service to the medical profession at a meeting of the Daviess County Medical Society in June. It was actually 53 years ago that Doctor Sherman began the practice of internal medicine in South Carrollton. In 1914 he moved to Lewisport and stayed there until 1924 when he came to Owensboro.

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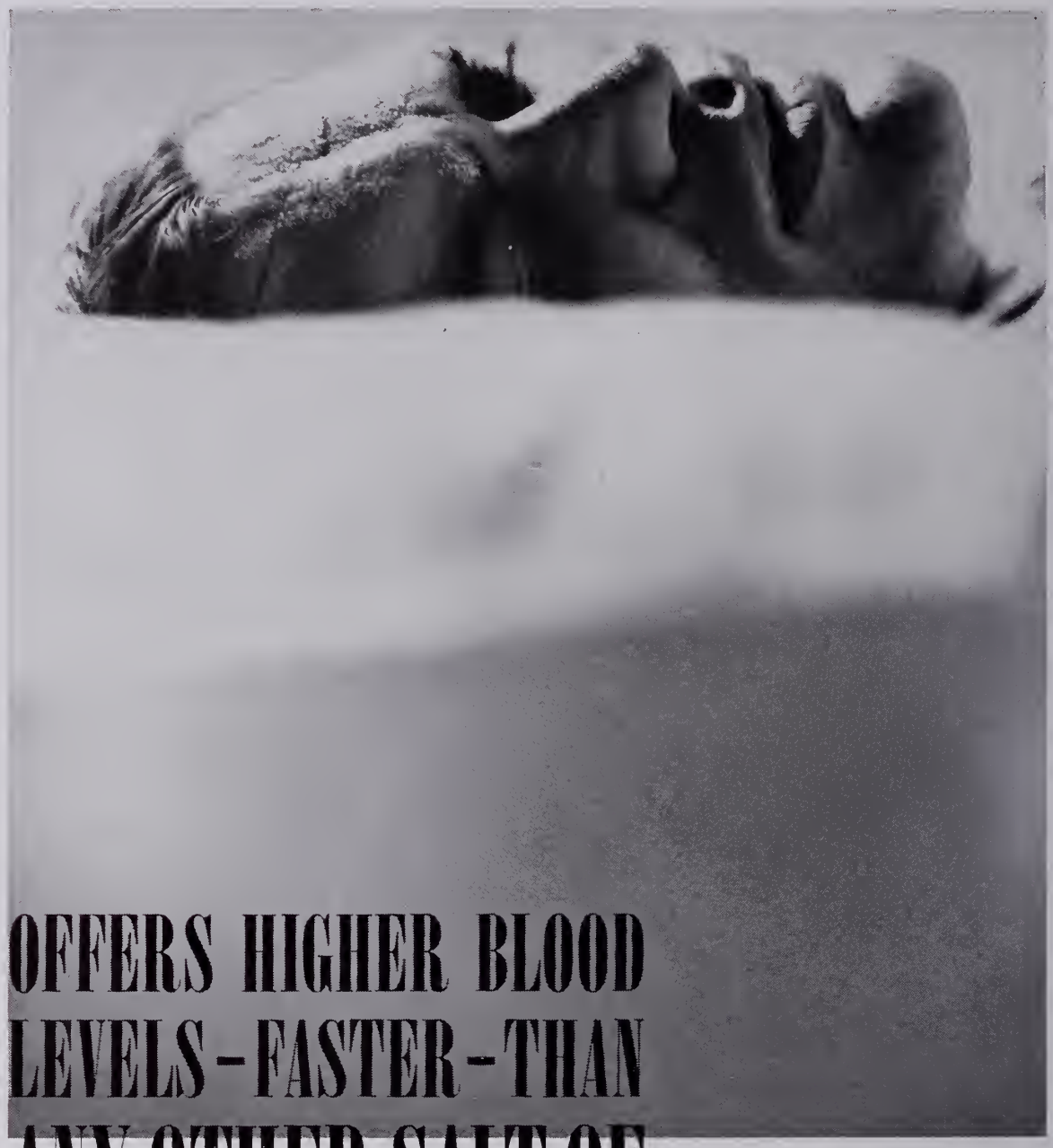
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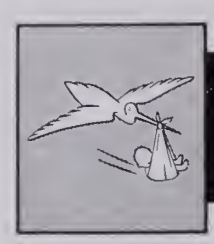


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From the files of the COMMITTEE FOR THE STUDY OF MATERNAL MORTALITY



Case #35: This patient was a 38-year-old married white primagravida who had her prenatal care under another physician 50 miles away. Her LMP was 6/2/57, by menses she was due March 9, 1958. She had an initial episode of profuse vaginal bleeding at 10:00 A.M. February 27, 1958 and was transferred by ambulance to the hospital. Examination at 1:20 P.M. revealed the patient in active labor in no distress, clinically 39 weeks pregnant, the FHT was heard in the RLQ, the rate 144. She was very tender in the RLQ and was having slight bloody show. The contractions were moderately hard every three minutes. Vaginal examination revealed a vertex presentation as ROP at the midpelvis. The cervix was effaced, three fingerbreaths dilated.

The diagnosis of a near term pregnancy in active labor was made with partial premature separation of the placenta with moderate concealed hemorrhage. It was felt the patient would safely deliver vaginally. At 1:30 P.M. she was given 100 mg demerol and 30 mg sparine i.m. She was given 50 mg of demerol, scopolamine ½cc and lorfan 1.0 cc at 3:35 P.M., the contractions were hard every 3 minutes, her blood pressure 130/90, the FHT 162. The cervix was completely dilated, and she was taken to the delivery room.

She delivered a 7 pound, 4 ounce girl at 5:41 P.M. under general anesthesia $N_2O + O_2$ 80-20 mixture and a midline episiotomy. The placenta delivered at 5:44 P.M. intact. The blood loss including clots was estimated at 400 cc. She was given 1 ampoule of methergine i.v. at 5:45 P.M. and 1 ampoule of 1cc pitocin i.m. at 5:55 P.M. The anesthesia ended at 6:00 P.M., the patient's pulse was 84 and blood pressure 102/72. Her condition on leaving the delivery room was described as good.

At 8:00 P.M. the patient was found in shock, her pulse was 110, weak and irregular. Her skin was cold and clammy. She was found to have moderate bleeding with the fundus fairly firm. Her blood pressure at 8:30 P.M. was 50/0, pulse 110. The fundus was moderately firm with little evidence of bleeding. She still felt cold and clammy. It wasn't mentioned if she was taken back to the delivery room and re-examined for source of bleeding.

She was given lorfan by mistake when levophed was ordered, but the amount received was less than 1 cc.

An infusion of 4 cc leophed in 500 cc N/S was started at 9:00 P.M., ergotrate 1/320 gr i.m., and 1000 cc whole blood was ordered. At 9:45 P.M. her blood pressure was 110/56, her pulse strong and regular.

Five hundred cc blood was started at 10:00 P.M., but she received only 150 cc, her color was described as good, pulse strong and her skin warm. The blood was restarted with poor results. They attempted to do a veneotomy. At 10:25 P.M. her color was pale, respiration slow and shallow, 12 per minute. No pulse. The second 500 cc of blood was started at 11:30 P.M. She had no apparent respiration at 12:00 A.M., and had a very irregular and weak pulse. 500 cc blood started at 12:10 A.M., but at 12:15 A.M. she was pronounced dead 7 hours postpartum. An autopsy was refused.

Cause of death on certificate: Shock due to prepartum, and postpartum hemorrhage, due to partial premature separation of placenta.

Comment

The committee felt this case represented an obstetric death that was non-preventable. They questioned the exact cause of death thinking it was not due to hemorrhage from the information available but possibly due to the i.v. methergine.

If it was a reaction to the methergine it was not unusual. Schade studied the vasomotor properties of methergine and ergonovine and reported this in the American Journal of Obst. and Gyn. 61:188; 1951. He paid special attention to those patients with clinical histories of elevated blood pressure. In the entire series a rise in blood pressure was encountered in 11% as compared to 30% in patients who had received intravenous ergonovine. This patient, however, was found in shock two hours postpartum (8:00 P.M.) and had "moderate vaginal bleeding, with a fairly firm fundus." After receiving an undetermined amount of leophed her blood pressure was essentially normal 110/56, her pulse strong and regular at 9:45 P.M. The bottom then again fell from the vascular system and the blood infiltrated and a veneotomy was necessary.

Without an autopsy we can only offer other possible conditions that would explain the sudden drop in blood pressure and death. Since this was a known abruptio, intra-abdominal bleeding must be considered, but you would also expect more vaginally. She could have had an undiagnosed rupture of an ovarian cyst, that is a dermoid, at the time of delivery resulting in a chemical peritonitis. These were two possibilities considered. In a hospital where autopsy facilities are available we can not honestly consider the patient had adequate care if this is denied.

topical strategy. . .

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Dosage: One Tussagesic tablet in the morning, mid-afternoon and evening, if needed.

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Remarkable
relief from
low back pain and
dysmenorrhea
Trancopal
THE FIRST TRUE TRANQUILAXANT

Here is
can expect
prescribe

for low back pain

case profile no. 2758*

A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*



what you when you

THE FIRST TRUE TRANQUILAXANT

Trancopal®

for dysmenorrhea
and premenstrual tension



case profile no. 3347*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

THE FIRST TRUE TRANQUILAXANT

Trancopal

potent muscle relaxant

effective tranquilizer

- In musculoskeletal disorders, effective in 91% of patients.[1]
- In anxiety and tension states, effective in 88% of patients.[1]
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal:
Low back pain (lumbago, etc.)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow, etc.
Myositis
Postoperative muscle spasm

Psychogenic:
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism



Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

1. Collective Study, Department of Medical Research, Winthrop Laboratories.



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. . . Time-tested flavor that children love, plus the tested effectiveness and safety of KYNEX. Just one dose sustains plasma-tissue levels for 24 hours. Sensitivity reactions and renal toxicity are rare in recommended doses. Highly economical regimen . . . easily administered and easily remembered by the mother.

Indicated whenever sulfas are indicated



ACETYL PEDIATRIC SUSPENSION

N[1] Acetyl Sulfamethoxypyridazine

Recommended dosage: First-day dose is 1 teaspoonful (250 mg.) for each 20 lbs. body weight up to 80 lbs. For each day thereafter, ½ teaspoonful for each 20 lbs. For 80 lbs. and over, use adult dosage of 4 teaspoonfuls (1.0 Gm.) initially, and 2 teaspoonfuls (0.5 Gm.) daily thereafter. Administer after a meal.

Supplied: Each teaspoonful (5 cc.) contains 250 mg. of sulfamethoxypyridazine activity. Bottles of 4 and 16 fl. oz.

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there's pain and inflammation here... it could be mild or severe, acute or chronic, primary or secondary fibrositis—or even early rheumatoid arthritis

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more manageable corticosteroid dosage

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. . . simple, flexible dosage schedule



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Sigmagen®

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Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
Ascorbic acid	20 mg.

Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

Acute conditions: Two or three tablets four times daily. After desired response is obtained, gradually reduce daily dosage and then discontinue.

Subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

Precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.

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GYNECOLOGIC ENDOCRINOLOGY: by Gardner M. Riley, Ph.D.; published by Paul B. Hoeber, Inc., Division of Harper Brothers; New York, 1959; 330 pages, $8.50.

The author, an outstanding endocrinologist and cytologist working with clinicians, presents a concise and up-to-date review of the subject.

The book can be divided into three sections:

Section I, Endocrine Physiology, is especially outstanding in its discussion of the pituitary gland and also the hormones during pregnancy and lactation.

Section II, a clinical presentation from birth to senescence, is a clear, concise, and up-to-date discussion in theory and therapy.

Section III, diagnostic procedures, steroid hormone therapy, and endocrine preparations, gives one the technical details and application of the diagnostic procedures of endocrinology. Suggestions are given indicating the endocrine preparations to use and the means of keeping up with new preparations.

This publication is an excellent, up-to-date review of endocrinology status, both from physiological and pathological viewpoints, as found during life for the student or clinician, and those who wish to keep abreast with the progress in endocrinology.

W. O. Johnson, M.D.

NOW OR NEVER, The Promise of the Middle Years: by Smiley Blanton, M.D., with Arthur Gordon; published by Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959; 273 pages; price, $4.95.

Jack Benny highlighted a common human anxiety by celebrating his thirty-ninth birthday annually for a score of years. In "Now or Never," Dr. Smiley Blanton notes the frequency of emotional breakdowns in these early middle years. Lacking the support of youth's enthusiasm and stamina, many break under the stress of "everybody's demon," anxiety.

The author, a youthful seventy-six, became established as a psychiatrist in his mid-forties. His careers as a teacher, actor, public official and physician have given him varied viewpoints. He has added abundantly to his understanding of people, serving large numbers of them as a counsellor and psychotherapist in a religo-psychiatric clinic.

A strong faith in people and their ability to change the course of their lives is revealed by the simplicity of the methods recommended by the author. He convincingly describes ways by which a reader might make an honest survey of himself. Self-deception and self-sufficiency may successfully bar discovery of conflicts. Yet many, by following the writer's clearly described initial step, self-evaluation, should be ready for a healthier and happier way of living.

Existential anxieties, those of death, old age and poor health are to be accepted. Relief of neurotic anxieties requires professional guidance. Facing the realistic problems and working out the best solutions are the answers for the situational anxieties. Changing goals, developing a balance between selfishness and altruism are other simple sounding remedies.

Dr. Blanton is too experienced in psychotherapy to suggest that maturing is so easy. He believes that people, unaware of the destructiveness of their hidden aggressions, can learn of them. In this high noon of the middle years the reader can then choose to be saint, devil, or a balanced, tolerant, healthy and happy human being.

At times the author appears too direct and authoritative yet never hostile toward people. His refreshing statements of his religious beliefs bespeak a deep affection for people as well as a faith in a personal God.

Throughout this book, despite dramatizations and occasional wanderings into areas bordering on fancy more than fact, Dr. Blanton pursues his theme with a touch, resilient strength. His advice to those who have done their best: "Having done all, stand," is a fitting conclusion to a book that should prove helpful both to doctors and their many anxiety possessed patients.

Arthur R. Kasey, Jr.

NAVY SURGEON: by Rear Admiral Lamont Pugh, Retired; published by J. B. Lippincott Company, Philadelphia and New York; 459 pages.

The jacket on this book reads as follows:

"In NAVY SURGEON, Lamont Pugh, ex-Surgeon General of the United States Navy, tells the story of his exciting, wide-ranging life— and an interesting story it is, full of action and shrewd observation, of the sights and sounds of our world in peace and war.

"Born on a farm in the hill country of Virginia, Lamont Pugh now lives at a spot less than ten miles from his birthplace. But in the intervening years he traveled literally millions of miles to all parts of the earth, saw civilization progress all the way from the oxcart of his childhood to the jet airplane, and played a vital part in the phenomenal accomplishments in medicine and surgery during that time.

"Admiral Pugh also served his country during three wars. He enlisted in the Marines during World War I; and among the important posts he held during World War II was that of Chief of Surgical Service at the Pearl Harbor Naval Hospital and later at the San Diego Naval Hospital. At the time of the Korean conflict he was Surgeon General of the Navy.

(Continued on Page 1000)



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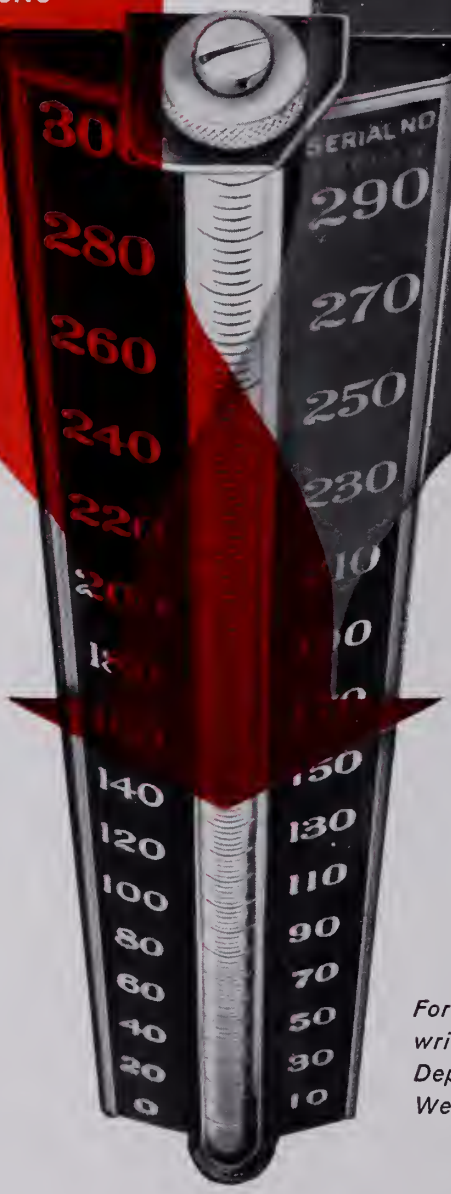
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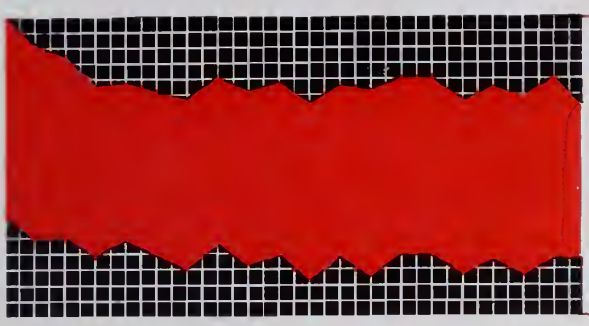
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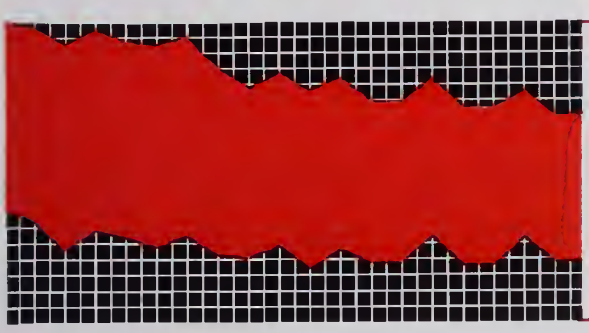
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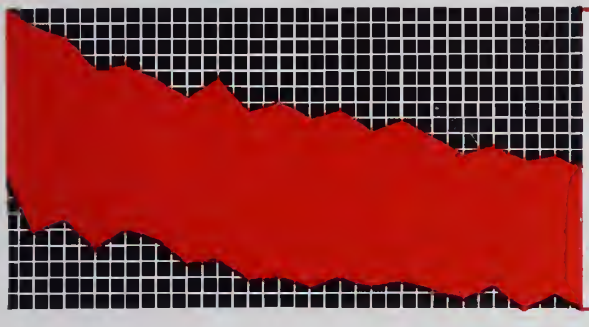
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- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
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- Arrest or reversal of organic changes of hypertension may occur.
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- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25
25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

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50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

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In The Books

(Continued from Page 996)

"With affection, candor and salty wit, Lamont Pugh tells of his boyhood, his years in medical school, and his long, distinguished naval career. He writes of outstanding cases he has treated, interesting and famous people he has known, his travels to some of the remotest and most exotic spots on earth, of world affairs, government and politics, and of his own philosophy of life.

"NAVY SURGEON, an unmistakably American story, is more than autobiography, it is a record of recent history, told by a man who has lived it."

So far as I can determine the above is essentially an accurate resume. I say "essentially" because this reviewer has a little difficulty agreeing with the use of the word "interesting" and of the phrase "salty wit." It is so easy to write destructive criticism, and there is certainly no possible need for saying anything unkind about this effort, and yet it seems the responsibility is upon the book reviewer to give you his honest opinion.

As a retired medical officer in the United States Naval Reserve, I have a warm affection for the Navy. I have never met Admiral Pugh, but we have many friends in common, all of whom have a high respect for him personally as well as his many accomplishments in the Navy. No where along the line have I ever heard him lauded for literary ability.

Whenever you have an impulse to "write that book" in view of your very useful and productive life, it might be well for you to read *Navy Surgeon* and forget the whole thing.

William K. Keller, M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

EVALUATION OF THE PELVIS IN OBSTETRICS: by Charles M. Steer, M.D., published by the W. B. Saunders Co., Philadelphia and London.

PREVENTIVE MEDICINE: edited by Herman E. Hilleboe, M.D.; published by W. B. Saunders Company, Philadelphia and London.

SURGERY OF THE FOOT: by Henri L. DuVries, M.D.; published by the C. V. Mosby Company, St. Louis.

SYNOPSIS OF TREATMENT OF ANORECTAL DISEASES: by Stuart T. Ross, M.D.; published by the C. V. Mosby Company, St. Louis.

TEXTBOOK OF PEDIATRICS: by Waldo E. Nelson, M.D., published by W. B. Saunders Company, Philadelphia and London.

Washington News—

(Continued from page 906)

a routine office visit. The other relative values for medical services are multiples of the basic unit. For example:—an appendectomy, 30 units; allergy skin tests, 2.0 units per 10 tests with a maximum of 15 units for multiple tests; anesthesia, first half-hour or any fraction thereof, 4.0 units.

It is not mandatory that the District Medical Society members charge fees conforming to the relative value scale. It was designed to show the relative value of a physician's services, particularly for health insurance purposes.

The AMA House of Delegates unanimously approved last year the study of relative value scales by state medical societies.

NEWS ITEMS

Carroll Brooks, M.D., has become associated in general practice with **William R. McCormack, M.D.,** and **Luther M. Wilson, Jr., M.D.,** Bowling Green. A native of Memphis, Tennessee, Doctor Brooks received his M.D. degree from the University of Louisville in 1958 and interned at St. Mary's Hospital, West Palm Beach, Fla.

Walter A. Cole, Jr., M.D., has opened an office in Radcliff for the general practice of medicine. A graduate of the University of Louisville in 1956, he interned at Duval Medical Center in Jacksonville, Fla., and has just completed a two-year tour of duty with the U. S. Air Force with the rank of Captain. He is a native of Hodgenville.

James W. Roney, M.D., is now associated with **P. J. Murphy, M.D.,** in the general practice of medicine in Lebanon Junction. Doctor Roney, a native of La Grange, graduated from the University of Louisville School of Medicine in 1958 and interned at St. Joseph Infirmary in Louisville.

R. Burke Casper, M.D., who was formerly in general practice in Brandenburg, has opened an office in Louisville. Doctor Casper graduated from the University of Louisville Medical School in 1950 and interned at Fitzsimons Army Hospital in 1950-1. A Louisville native, he was a captain in the Army Medical Corps from 1950-52.

M. S. Akaydin, M.D., a native of Turkey, has been appointed clinical director at Western State Hospital. Doctor Akaydin, a psychiatrist and trained specialist in hypnosis, has been chief of the medical staff at the hospital since February, 1958.

Against the "Vaginitis Spectrum"

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A welcome clinical advance...
effective medication
in an appealing form



Soft and pliant as a tampon, the Milibis vaginal suppository offers proved therapeutic action* in a vehicle giving unusual clinical advantages to both patients and physician.

COVERS CERVIX AND VAGINAL WALL—The pliant Milibis suppository disintegrates readily and molds itself to the cervix as well as the columns and rugae of the vaginal vault.

SHORT DOSAGE SCHEDULE—The short course of treatment with Milibis—only 10 suppositories in most cases—together with the clean, odorless, non-staining qualities eliminates psychic barriers which often interrupt longer treatments before complete cure.



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with applicator.

Now supplied with plastic applicator

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- INSURES CORRECT SUPPOSITORY PLACEMENT

MILIBIS® Vaginal Suppositories

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New York 18, N. Y.

*97 per cent effective in a study of 564 cases; 94 per cent effective in a series of 510 cases.

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PUBLIC HEALTH PAGE

Public Health Education— A Joint Responsibility

RUSSELL E. TEAGUE, M.D.

Commissioner of Health, Commonwealth of Kentucky

HEALTH education, as the term is understood in public health work, is the process which provides health knowledge and understanding to people, and, more importantly, motivates them to take action to obtain the highest possible level of individual and community health.

In order to improve health conditions, the participation of all or most individuals must be obtained. This is graphically demonstrated in such efforts as those to fluoridate community water supplies, to establish garbage collection and disposal systems, or to obtain a high level of community protection against communicable disease through immunization.

Health knowledge from reliable sources is becoming more and more widely available. And, fortunately, the maintenance of good health is a matter of personal concern to most informed people. But there remains a large proportion of the population who are not motivated to follow good health practices, either for themselves or for the community, unless special health education efforts are made by physicians and public health departments.

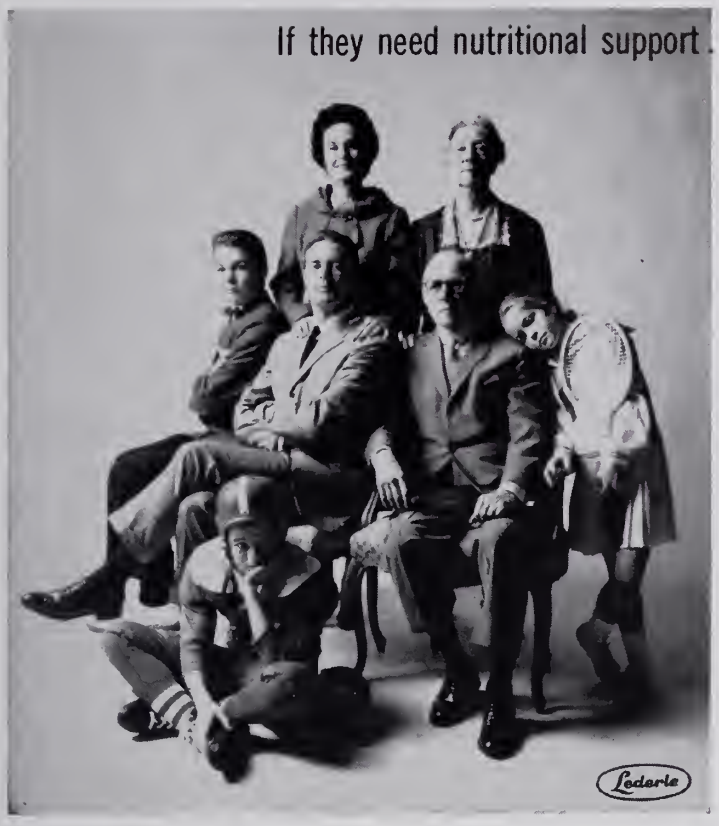
There is usually a lag of ten years or more from the time of medical and scientific discovery until its general acceptance and utilization. More than fifty years have been needed to make smallpox the medical curiosity it now is in this country, even though the vaccine has been widely available. The story of the Salk vaccine during the past three years, in which more than 72 million persons have been vaccinated and the incidence of poliomyelitis has dropped gratifyingly, is a remarkable one. Seldom, if ever, have so many persons taken advantage so quickly of a preventive health measure. Yet too few have had the full series of injections, and there remain too many who have received no protection at all. Translating what medical science knows—and has provided—into effective action must still be accomplished. Health education seeks to dispel ignorance, overcome apathy, fear or even antagonism, and to replace negative attitudes with positive motivations for good health.

The methods of public health education are those of the teacher, the psychologist, the publicist, the group worker and the community organizer. Its objectives are centered around the goals of specific health programs, such as gaining wide public participation in case-finding, immunization or community sanitation programs.

The State Department of Health contributes to the health education efforts being made in Kentucky by maintaining a Division of Public Health Education with a staff trained in information, group work and community organization techniques. This division works closely with all other divisions, with the county health departments, with medical and related health groups, and with voluntary health agencies and civic and social organizations interested in gaining effective utilization of health and medical services, disease prevention and health protection. A wide variety of health information material is distributed. Among other materials, in the last year health films were shown 6,370 times to 475,000 persons; 230,000 pamphlets were given out; exhibits were displayed at major conventions and fairs; newspaper, radio, and TV releases and programs were used regularly, and articles were prepared for magazines and professional journals. The *Bulletin*, official bimonthly publication of the Department of Health, is edited by the Division and circulated to 20,000 persons, including all physicians in Kentucky. Health educators assisted 92 counties with community organization activities to enhance local programs.

It must be pointed out that the State Department of Health and the county health departments cannot alone achieve a high level of public health education. We seek to join our efforts with the many others who share this professional responsibility. Among these, occupying perhaps the most strategic role, are physicians in each community. To assist them in their constant effort to improve individual and community health, the facilities of the Department, including the health education materials and services of the Division of Public Health Education, are available.

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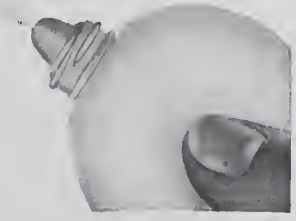
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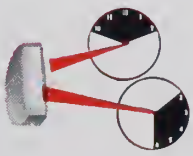
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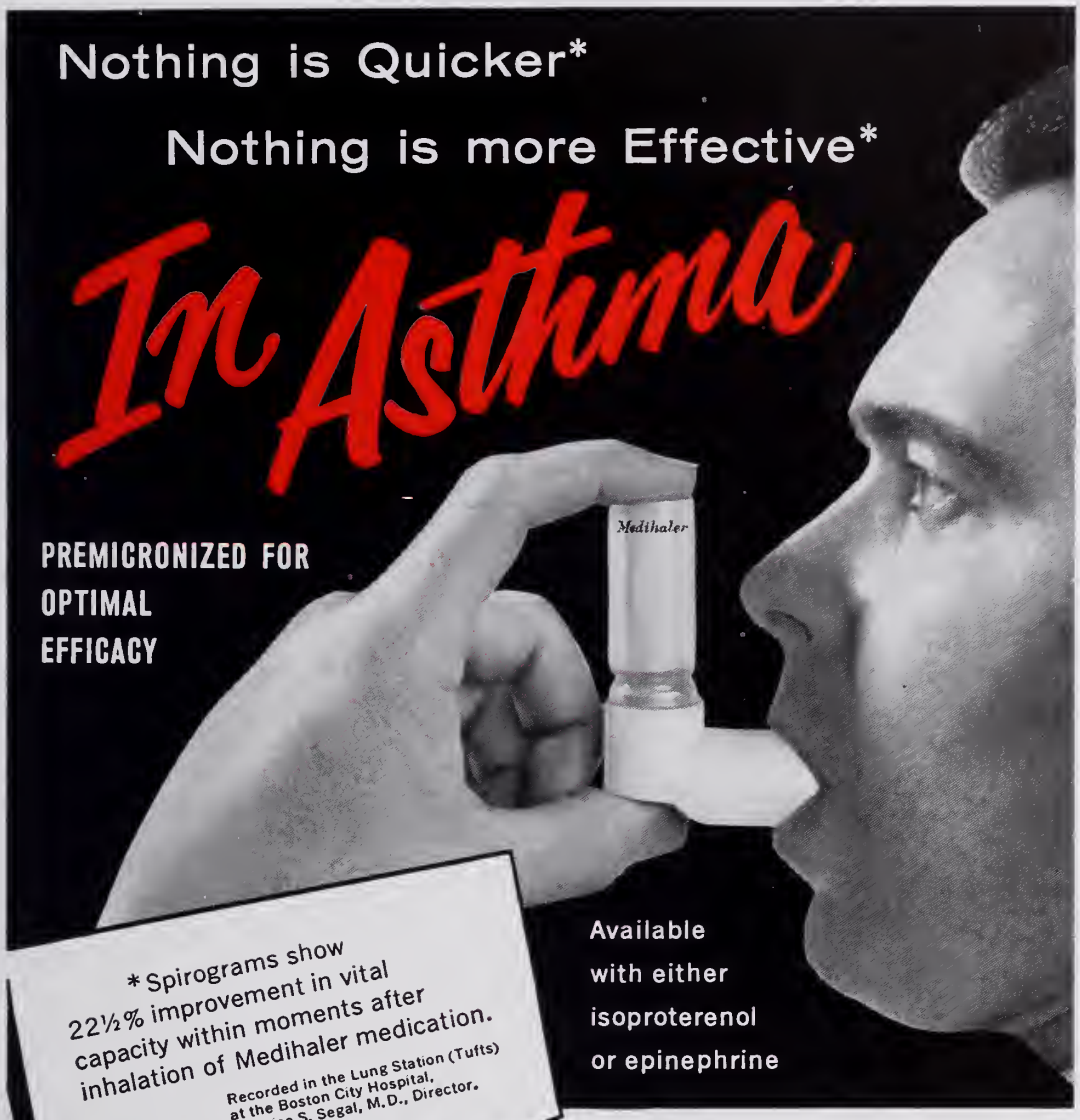
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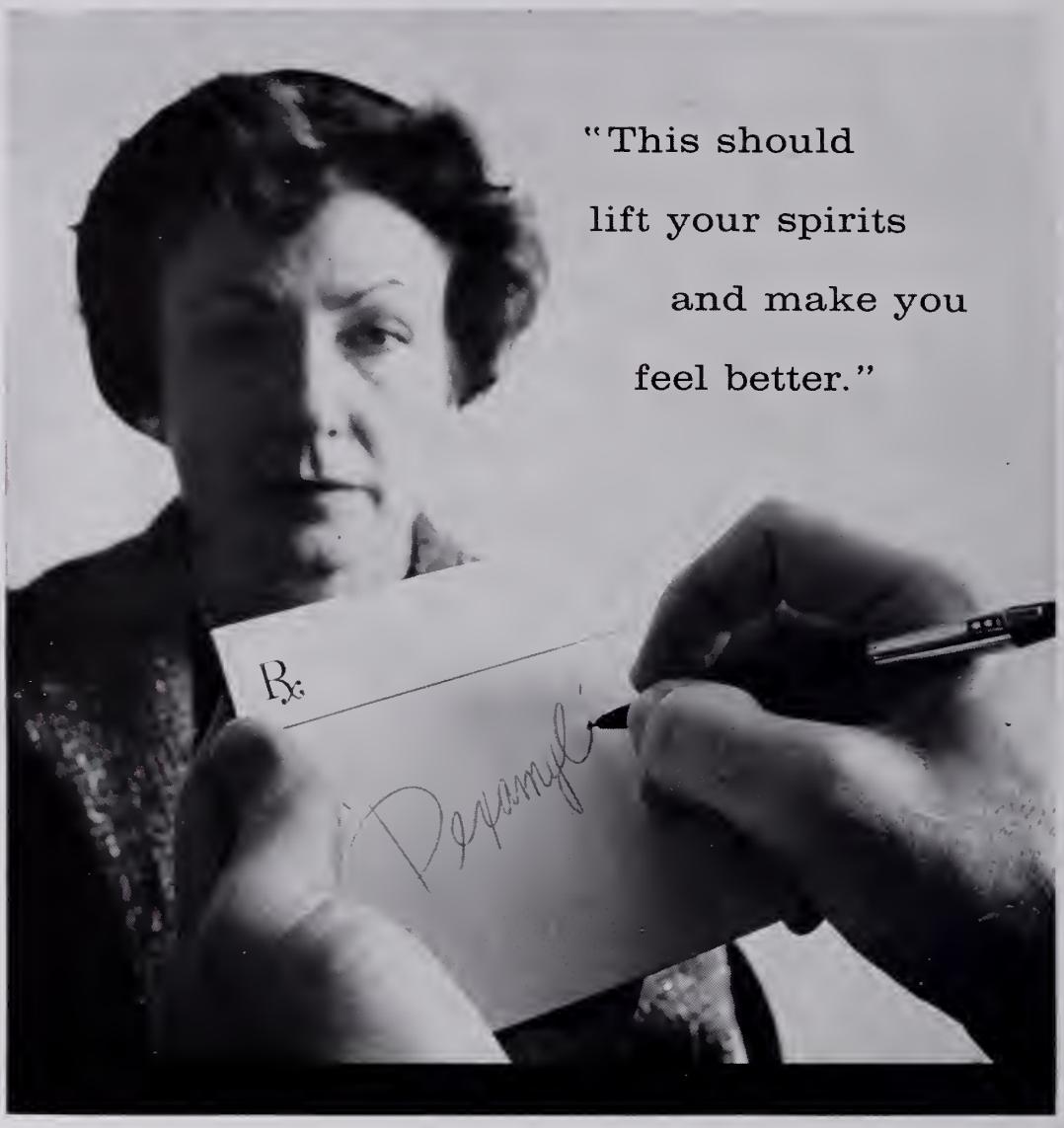
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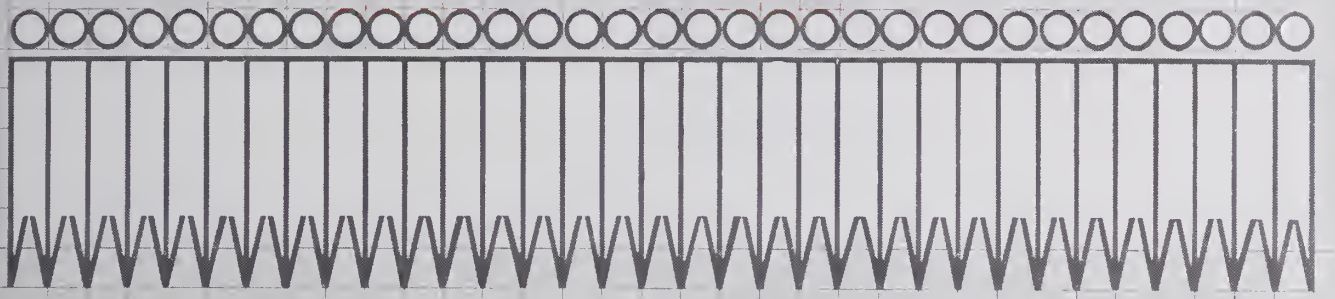
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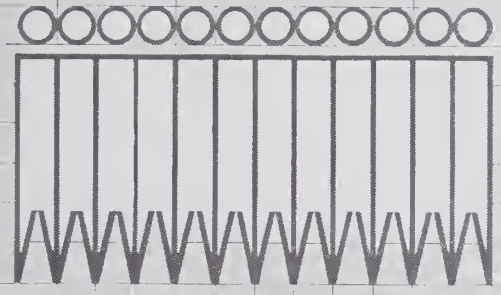
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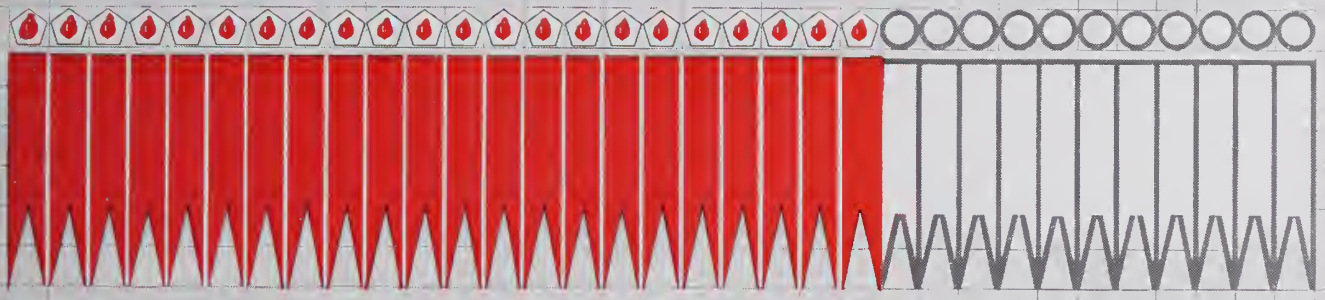
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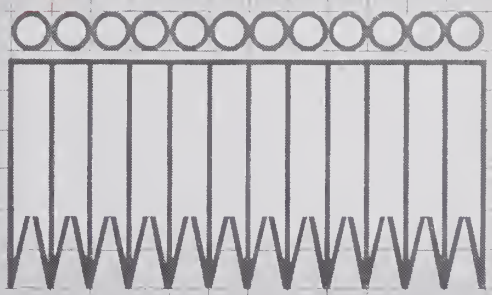
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message from the President

A year has now passed since I accepted the gavel and started my term as President of this fine Association. I well recall my feelings that night; pride in the appointment, determination to do well, and dubiousness about my ability to fill the position.

However, as time progressed, I found myself possessed of greater confidence and my task seemed to become progressively lighter. Now I know that these things happened, not because of myself, but because of you, and the unselfish support of the Council, President-Elect, our Vice Presidents, our Committees, and last, but not least the untiring efforts of our Headquarters Office. Perhaps I should join with the ancient philosopher, who said, "The happier the time, the quicker it passes." This year has flown with wings.

My friends, to close this last official page of mine, I should like to make a final request. We still have problems to solve and difficulties to face. Our new President will meet many responsibilities in the next twelve months, and I am going to ask all of you to give him every possible assistance, to accord him your moral and physical support, and to offer your help before he finds it necessary to ask for it. Give my good friend Doctor Irvin Abell, Jr., the encouragement and friendly understanding that has proved such an aid to me the past year. It will long remain vivid in my memory, largely because of the helping hands directed toward me when needed most.

Gentlemen, for the honor bestowed on me a year ago, and for the way in which you helped me to discharge my obligations to the Association, my most sincere thanks.

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(equivalent to 2 cc. poregoric)	

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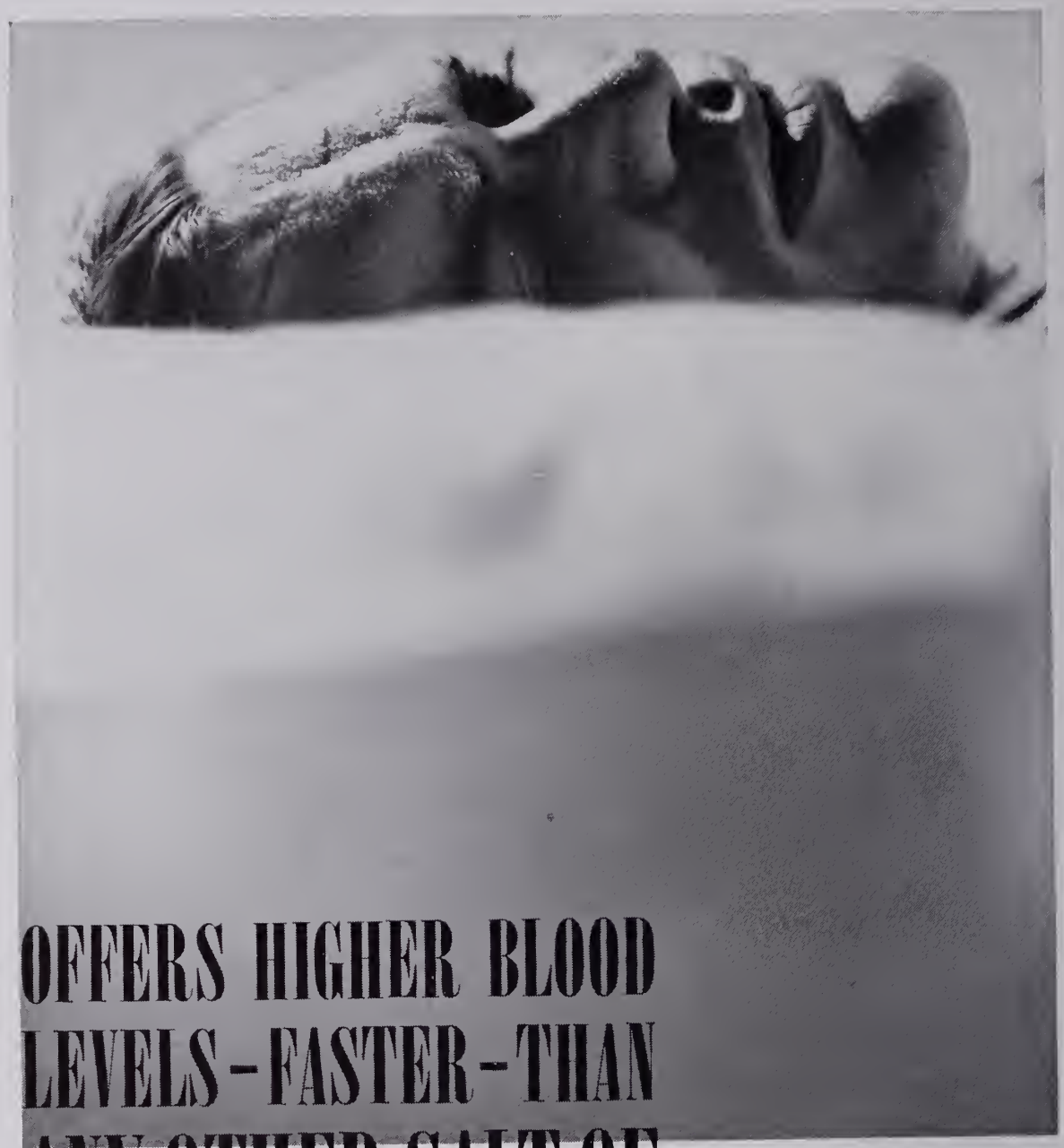
Bottles of 16 fl. oz.
Exempt Narcotic.
Available on Prescription Only.

DOSAGE:

ADULTS: Initially 1 or 2 toblespoons from four to six times daily, or 1 or 2 teospoons ofter eoch laase bowel movement; reduce dosage os diarrheo subsides.

CHILDREN: ½ teospoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced ta five doily, then every eight hours for three days.

Winthrop LABORATORIES
New York 18, N. Y.



OFFERS HIGHER BLOOD LEVELS—FASTER—THAN ANY OTHER SALT OF ORAL PENICILLIN:

COMPOCILLIN®-VK

Potassium Penicillin V

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in tiny, easy-to-swallow Filmtabs® in tasty, cherry-flavored Oral Solution

908129

Supplied: Compocillin-VK Fitmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. Compocittin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonfut represents 125 mg. (200,000 units) of potassium penicillin V.

ABBOTT



running noses and open stuffed noses orally



Triaminic®

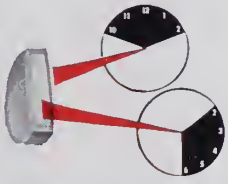
the leading oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

safer and more effective than topical medication[1,2,3]

- systemic transport to all respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each TRIAMINIC Tablet provides:
Phenylpropanolamine HCl .....50 mg.
Pheniramine maleate .....25 mg.
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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new hope for fetal salvage

DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

According to Tyler and Olson,[5] "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . . ."

DELALUTIN BABIES WHOSE MOTHERS WERE HABITUAL ABORTE



Mary Ann Cribben
Garden City, N. Y.



Amy Sue Greenman
Lincolnwood, Ill.



William Peller
Skokie, Ill.



Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knudsen
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H-W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

LUTIN

improved progestational therapy

SQUIBB HYDROPROGESTERONE CAPROATE

DELALUTIN offers these advantages over other progestational agents:

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum afterpains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

Administration and dosage:

Because of its low viscosity, Delalutin may be administered with a small gauge needle (deep intragluteal injection). Complete information on administration and dosage is supplied in the package insert.

Supply:

Delalutin is available in vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in sesame oil, and benzyl benzoate.

ch of these healthy, normal babies was born by a mother with a documented previous history true habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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Roselle, Ill.



Rosanne Guberman
Elmont, L.I., N. Y.



Kenneth Michael Simonson
Denver, Colo.



Daniel A. Fabrizio, Jr.
No. Massapequa, L.I., N. Y.



anne Verdcrosa
Seaford, N. Y.



J. Gettemy
Hartford, Conn.

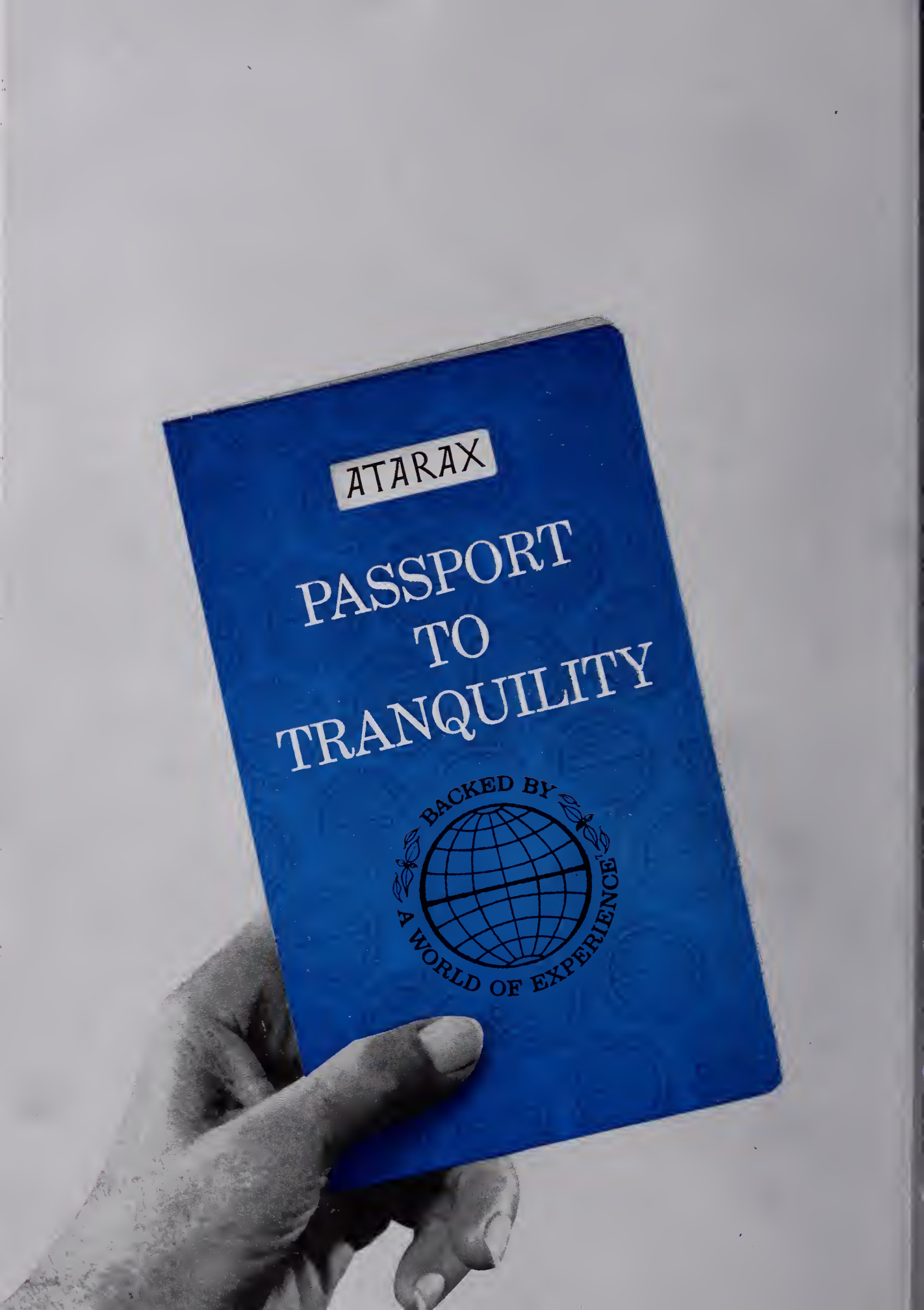


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☞ widest latitude of safety and flexibility

No serious adverse reaction ever documented – five dosage forms and sizes

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Not a phenothiazine or a meprobamate

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These unique benefits in specific indications

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Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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Science for the World's Well-Being

For those patients who complain

carries your patients through the middle of the night





Each Nebralin timed-release tablet contains:

Dorsital* ..... 90 mg.
Warning: May be habit forming

Mephenesin ..... 425 mg.

*Dorsey brand of pentobarbital

CAUTION: Federal law prohibits dispensing without prescription

Dosage: One or two tablets ½ hour before retiring

about waking up at 2 A.M.



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timed-release tablet

timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2, 3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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THE INSURANCE PAGE



FOLLOWING the 1958 annual meeting of the Kentucky State Medical Association, the President of the KSMA, Doctor R. W. Robertson, appointed a new committee, in accordance with the instructions of the House of Delegates. This committee, "The Medical Advisory Commission of the KSMA to Kentucky Blue Shield," is composed of 20 members, who have been chosen from various medical specialties, as well as from the general practice group, and who were also selected to give representation from various sections of the State. The function of this commission is to work with our Kentucky Blue Shield Plan in developing improved methods for furnishing the people of our state, prepayment mechanisms with which to provide for their health care.

In the past few months the Commission has held several meetings to consider ways and means of helping our Blue Shield plan to broaden and improve its coverage. Thus far, the discussions have been almost entirely centered around two projects which the Commission was directed to study, and concerning which it was expected to make specific recommendations.

The first of these, which was discussed in the "Insurance Page" of the July issue of the Journal, is the provision of insurance coverage against the costs of illness, for those of our "Senior Citizens" group, (65 and older) who have low incomes and limited resources. The American Medical Association has promised the people of our nation that this coverage can and will be provided on a voluntary basis, and it has urged every State Association to work with its Blue Shield Plan in developing such coverage.

The other task assigned to the Medical Advisory Commission was in the form of a directive from the Council of the KSMA. At the meeting of the Council on April 2, 1959, the Commission was instructed to "work with the Staff of Kentucky Physicians Mutual in the development of a plan providing coverage on a service basis for the people in Kentucky."

On July 2, 1959, the Advisory Commission to Blue Shield met to consider these two items. By special invitation, Mr. Richard Nelson, of the AMA Headquarters Staff appeared before the Commission to describe the progress made in other states on old age coverage; and Doctor Ira Layton, of Kansas City, Mo., who is Vice-President of a large Blue Shield Plan that operates on a service basis, gave his reasons for preferring a service to an indemnity plan.

The staff of Kentucky Physicians Mutual then presented the plans which they had been requested to develop; (1) a contract for the old age, low income group; and (2) service contracts for coverage of those other than the aged whose incomes are below certain specified levels.

The Commission, by a vote of 9 to 2, voted to recommend to the Council that it endorse a service type plan, (as it had already done, in effect, by its directive to the Commission); and that the plan for coverage of the old age, low income group, be on a service basis.

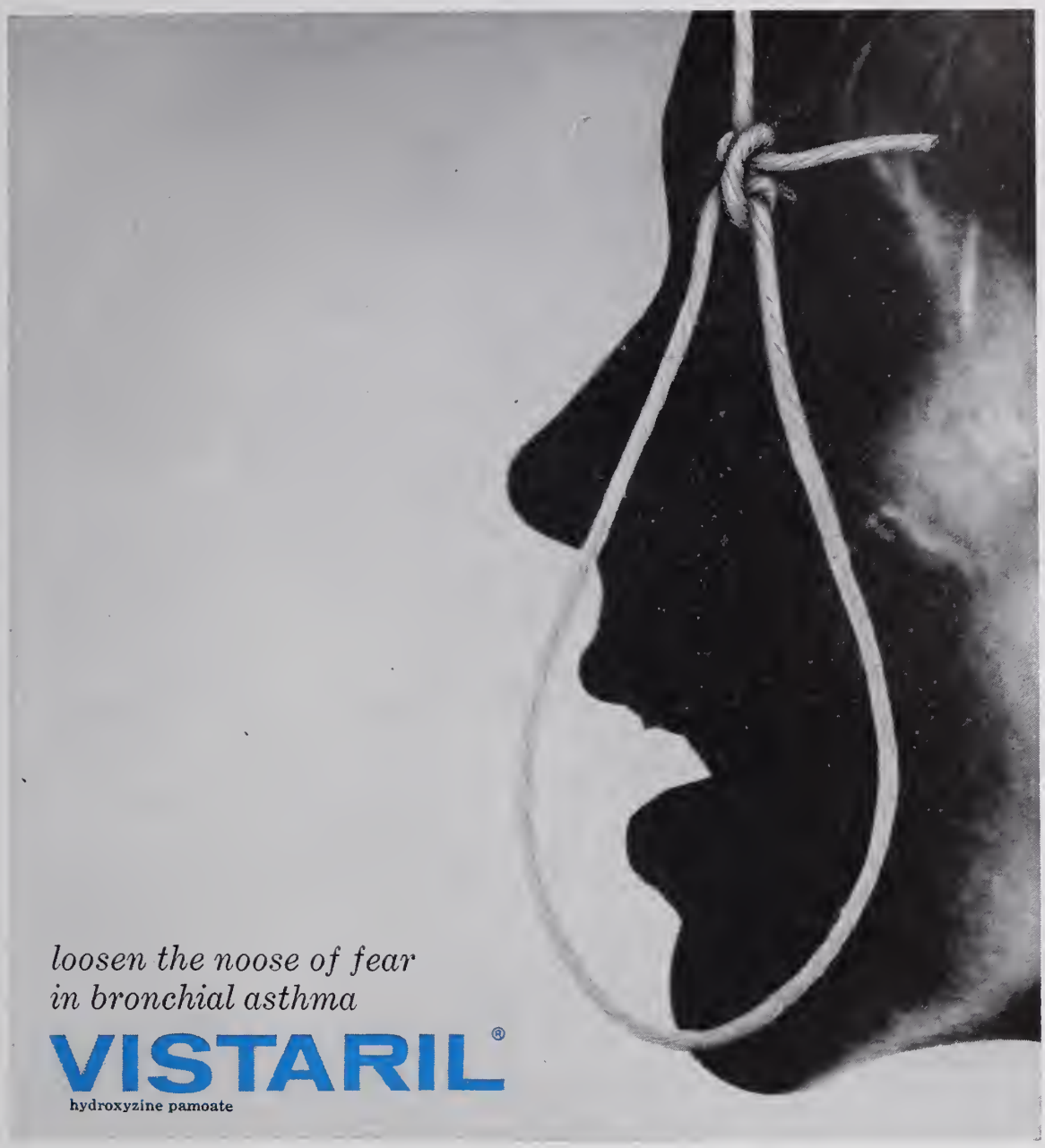
At the open meeting of the Council of the KSMA on July 30, 1959, these recommendations were presented to the Council.

Because of the highly controversial nature of these recommendations, and because it was recognized that the full and enthusiastic support of all of the physicians of our state will be necessary for the success of any type of Blue Shield plan that is adopted, the Council wisely chose to defer action on these matters. It was decided that a special session of the House of Delegates would be called to take action on the recommendations at a future date.

In order to make it possible to start a program for coverage of the aged, without further delay, the Council authorized the Advisory Commission to proceed with helping our Blue Shield Staff in developing an indemnity type contract for the group over 65 who have low income and limited resources. This contract should be ready for approval and for sale, in the near future.

In order to enable every member of the KSMA to acquaint himself with the differences between service and indemnity Blue Shield plans; and to weigh for himself the arguments for and against each type of plan, the "Insurance Page" of the Journal will present, in an early issue, a full page article expressing the viewpoint of a physician who favors an indemnity contract; and on the opposite page, the views of a physician who favors a service contract. It is hoped that every member of the State Association will read these articles carefully.

W. Vinson Pierce, M.D.



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Vistaril was designated as a psychotherapeutic antihistamine by the A.M.A. Council on Drugs in 1958. A professional information booklet providing complete details on Vistaril is available on request.

Suggested oral dosage – adjust according to response: Adults, 50 mg. q.i.d., initially. Children over 6, 50-100 mg. daily in divided doses. Children under 6, 50 mg. daily in divided doses.

Supplied as Capsules – 25, 50, and 100 mg.; bottles of 100 and 500.
Oral Suspension – 25 mg. per teaspoonful (5 cc.); 1 pint bottles.
Parenteral Solution (as the HCl) – 25 mg. per cc.; 10-cc. vials and 2-cc. Steraject® Cartridges.

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"In a group of patients who habitually develop gastric distress to moderate dosages of aspirin...all tolerated the new preparation [Arthropan] exceedingly well..."[2]

"Patients who had been taking steroid preparations before using Choline Salicylate [Arthropan] were able to reduce the doses (of steroid) and in some instances to discontinue it entirely."[3]

"In no instances did gastrointestinal symptoms preclude administration of Choline Salicylate [Arthropan]."[4]

These reports have emanated from extensive clinical trials[5] in thousands of patients by more than 180 physicians.

RECOMMENDED DOSAGE: (Adults and children over 12 years) *As an anti-inflammatory agent in rheumatoid arthritis and rheumatic fever:* 1-2 teaspoonfuls, 4 times daily at onset of therapy. *As an analgesic or antipyretic:* 1 to 2 teaspoonfuls, 3 to 4 times daily.

NOTE: Unless satisfactory relief is obtained, it is advisable gradually to increase dosage by increments of 1 teaspoonful per day until maximum benefit, without side effects, is attained. *In every case the dosage should be adjusted upwards or downwards to assure full therapeutic activity up to the limit of the patient's tolerance (in the absence of gastrointestinal distress or early salicylism).*

Because of the special chemical structure of 'Arthropan', alkalies or other buffering substances are not required to protect the stomach wall and should not be administered with 'Arthropan'.

SUPPLIED: 16 and 8 oz. bottles. Each ml. of 'Arthropan' contains 174 mg. of Choline Salicylate. Each teaspoonful (5 ml.) contains 870 mg.

CITED REFERENCES: 1. Clark, G. M.: Personal Communication, 1958. 2. Feldman, H. A.: Personal Communication, 1958. 3. Scully, F. J.: Treatment of Rheumatic Disorders with Choline Salicylate (to be submitted for publication). 4. Friedland, C. K.: Personal Communication, 1958. 5. Complete data available on request to the Medical Director.

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for the acute asthmatic attack

rapid control by the oral route
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the *buffered* theophylline that permits adequate oral xanthine dosage...better absorbed and better tolerated than aminophylline...formulated to provide effective blood levels in just 15 minutes

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Dosage: Adults—2 tablespoonfuls t.i.d. Children—2 to 3 teaspoonfuls if over 12 years; 1 to 2 teaspoonfuls if 6-12 years; 1 teaspoonful if 3-6 years; ½ to 1 teaspoonful if 1-3 years. May be repeated after 8 hours.

Bottles of 1 pint, 1 gallon.

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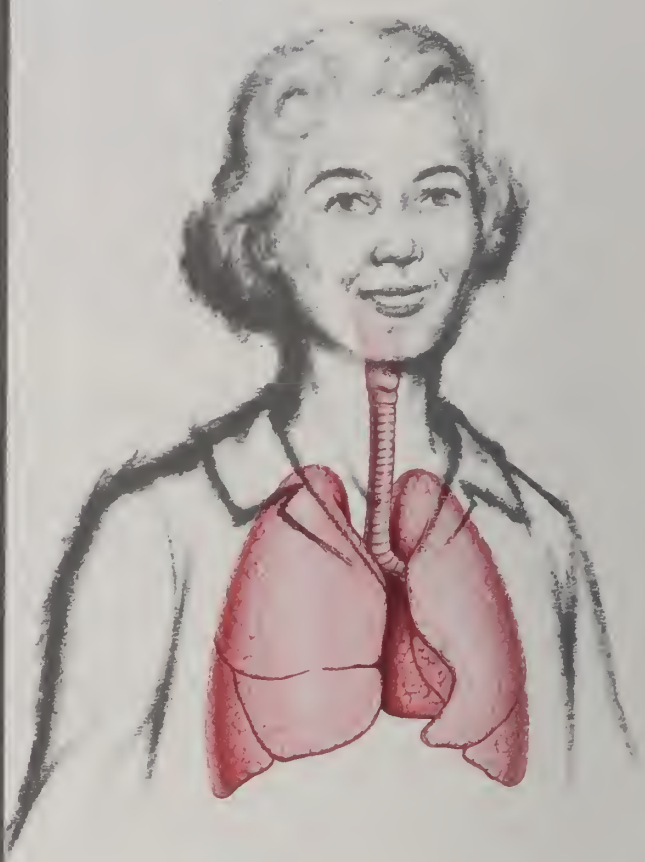
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Potassium Iodide	300 mg.
Secobarbital (Warning: May be habit-forming)	20 mg.
Niacinamide	40 mg.

Dosage: One tablet q.i.d. with water.
Bottles of 100, 500.

1. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 2. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.



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WASHINGTON NEWS DIGEST

WASHINGTON, D. C.—The House Ways and Means Committee has put aside until next year the so-called Forand bill which is opposed vigorously by the medical profession.

But supporters of the legislation have made clear that they will press for action by Congress next year when politics will be paramount because of the presidential and Congressional elections in November.

The Ways and Means Committee took no action on the legislation after five days of hearings highlighted by the Eisenhower Administration lining up with the medical profession in opposition to it.

Arthur S. Flemming, Secretary of Health, Education and Welfare, told the committee that "it would be very unwise" to enact such a bill. He warned of "far-reaching and irrevocable consequences." It would freeze health coverage of the aged "in a vast and uniform government system" and would mark the beginning of the end of voluntary health insurance for old persons, he said.

Secretary Flemming later promised to report to Congress early next year on possible atlernatives, including Federal subsidies to private carriers of health insurance for the aged. But he took no position on any of the alternatives for the time being.

Summing up the hearings, Dr. F. J. L. Blasingame, Executive Vice President of the AMA, said:

"It was shown that it would be most unfortunate for the federal government to move in for political reasons and attempt in a compulsory fashion to solve by legislation problems which are being thoughtfully considered at the state and local level by the medical profession and other dedicated members of the health team."

Main support for the bill, which was sponsored by Rep. Aime J. Forand (D., R.I.), comes from organized labor. The legislation would increase federal Social Security taxes to finance hospital, surgical and nursing home care for Social Security beneficiaries.

Although this bill has been shelved for the time being by the House Committee, the problems of the aged are being studied by a Senate Subcommittee headed by Sen. Pat McNamara (D., Mich.). The Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare has held public hearings intermittently in Washington. It also planned to hold hearings in various other cities.

In his second appearance before the Senate Subcommittee, Dr. Frederick C. Swartz, Chairman of the AMA's Committee on Aging, reported that state and local medical associations "have moved promptly" to make the AMA's six-point "positive health program" for the aged "an effective and workable instrument."

Dr. Swartz said that the problem of financing health services for the aged is "a temporary, not a permanent one "because" each year, more and more of the Americans who are reaching 65 are covered" by voluntary insurance.

*** ***

Democrats in Congress cut back their housing program further after President Eisenhower vetoed a $1.4 billion bill. Starting with a $2.1 billion program, Democrats came down to the $1.4 billion figure in an effort to avoid a veto although it was a more expensive program than Mr. Eisenhower wanted.

After the President vetoed this bill anyway, Democrats came up with a $1 billion bill which retained three provisions of interest to the medical profession.

They would:

1) provide construction loan guarantees by the Federal Housing Administration of up to 75 per cent of the cost of proprietary nursing homes; 2) authorize $25 million in direct loans for construction of housing for interns and nurses, and 3) authorize a $50 million revolving fund for direct loans to help private nonprofit corporations build rental housing for the elderly.

*** ***

Congress voted a compromise $400 million appropriation for medical research. The amount was about $80 million less than approved by the Senate, but was more than $100 million above the Eisenhower Administration's request for the National Institutes of Health.

The allotments for research in specific fields included: cancer, $91 million; mental health, $68 million; heart, $62 million; arthritis, $47 million; neurology, $41 million; allergy, $34 million.

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waterloo for an ulcer...

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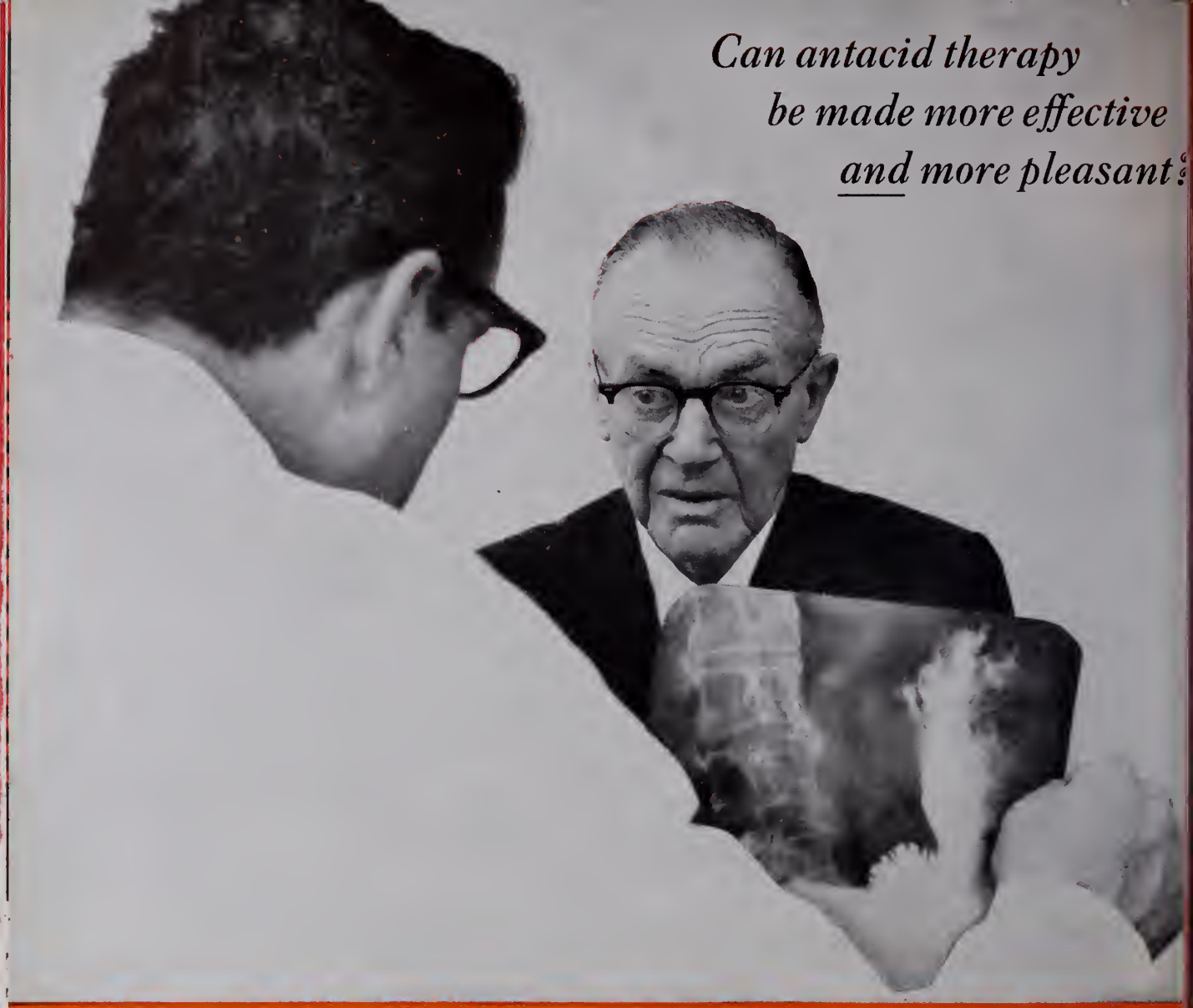


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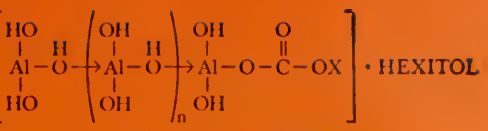
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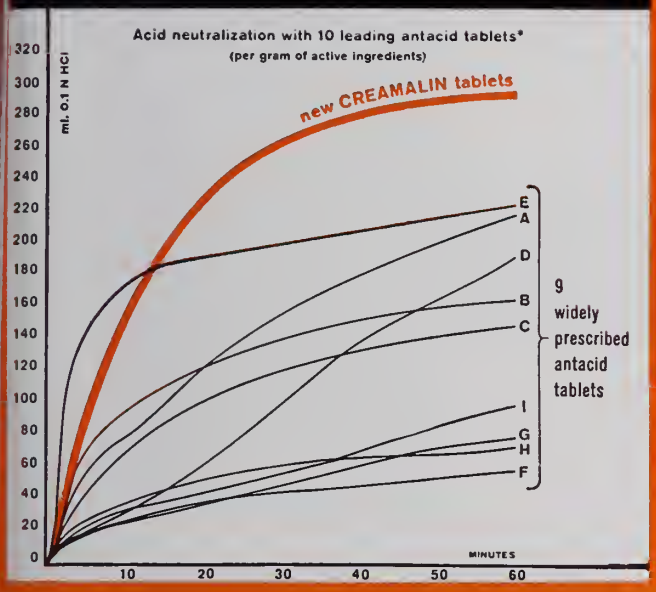
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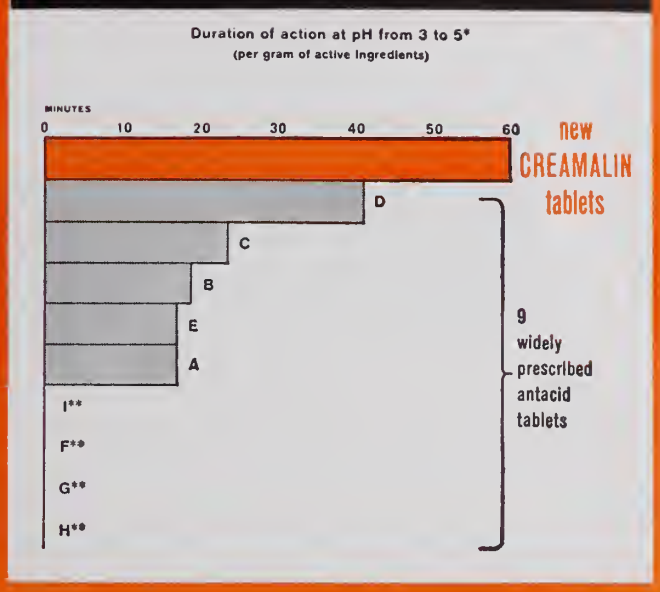
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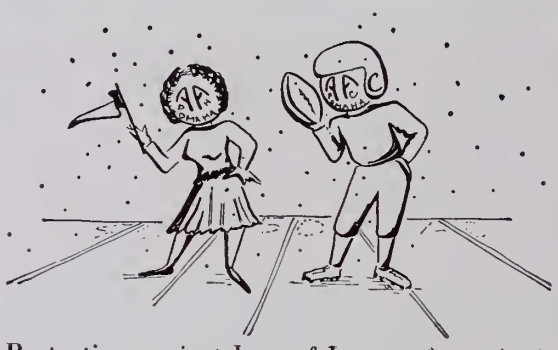
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An Evaluation of the Status of Vascular Disease

BENJAMIN B. JACKSON, M.D.*

Louisville, Ky.

OF necessity years must elapse before a prophylactic program can be successfully instituted in the management of atherosclerosis. In the interim surgical techniques must be employed in the therapy of vascular disease. Presently only the small end arteries of the vascular system remain unattacked by surgical effort. The larger vessels have been approached with major success. From those triumphs on the aorta and ileo-femoral arteries has spread the sedge brush fire that now encompasses the coronary,[17] mesenteric,[21] renal,[7] and cerebral circulations.[4,8]

Reason, however, must apply to these reconstructive operations. Such procedures must be embarked upon with full awareness of the associated risk as well as the probable successes. Often times the type of procedure can be envisioned from the arteriogram. This seems manifestly significant in view of the high incidence of diabetes, cardio vascular, and renal disease in patients undergoing reconstructive arterial surgery. However, rigidly selected, they appear to run a better chance of having circulation restored by surgical means than risking the loss of extremity or life from progressive arterial insufficiency.

In vascular surgery one fact remains preeminent. The blood flow must be adequate and remain uninterrupted. This implies an unimpeded proximal inflow, a satisfactory conduit, and an adequate distal outflow. A poor inflow from proximal obliterative disease or anastomotic stenosis will result in few successes. Degeneration of the homograft or endarterectomized artery by stenosis, aneurysmal formation, and extrinsic fibrosis, or deterioration of newly formed intima and kinking in a plastic prosthesis will frequently account for disappointing results. Compromise of the distal outflow bed from prexisting atherosclerosis is the most common cause of early failure in reconstructive surgery.

Consideration of vascular problems seems to be particularly dependent upon the presence of atherosclerosis. This fact necessitates a clinical division of problems into arterial trauma and degenerative vascular diseases. Vasospastic diseases per se are not within the scope of this paper.

Trauma

Arterial Injury: Trauma in the region of major vessels carries the potential of arterial insufficiency. There appears to be little excuse for neglecting the reconstruction of a major artery in the upper or lower extremities in almost any age group in which trauma is a major factor provided bone and soft tissue destruction do not preclude a functional limb. The immediate repair of arterial injuries will often prevent arteriovenous fistulae and false aneurysms.

In the absence of atherosclerosis the probability of successful reconstruction is excellent. Injury in the area of a major vessel with evidence of an impaired distal circulation de-

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mands exploration. If the vessel is incompletely divided or a short segment is involved, no graft need be employed. Simple suturing or a segmental resection with an oblique end to end anastomosis will frequently restore distal circulation. If a graft is required, a reversed saphenous vein autograft will usually be available. If infection is a major consideration, an inert prothesis, such as Teflon,® is most satisfactory.

The foregoing comments are especially pertinent to the younger age group in which collateral circulation is adequate to prevent gangrene but insufficient to prevent claudication. It is needless to remark that claudication in the working man is a most distressing problem.

Peripheral Arteriovenous Fistula: Usually a history of gun shot or stab wound is recorded. The patient reports a buzzing sound in the extremities or neck and a thrill may be palpated over the fistula. Severe cardiac complications may occur if the shunt is near the heart. If cardiac decompensation is not present, arterial reconstruction should be concluded before it becomes apparent. Bacterial vegetations at the fistulous stomata are prone to occur and argue for early repair.

An arteriogram is rarely helpful. Arteriovenous communications in minor vessels may be managed by ligation and excision. Fistulas involving the axillary, brachial, iliac, femoral (superficial and deep) vessels should be excised and arterial continuity restored by grafting. The parallel vein should also be repaired if postoperative pain and swelling is to be avoided.[11] Preoperative sympathectomy is rarely indicated.

Degenerative Vascular Disease

Aneurysms: Characteristically aneurysms involving the abdominal aorta are fusiform. The underlying disease appears to be atherosclerosis complicated by varying pressure and volume in flow. Abdominal aneurysms occur distal to the renal vessels in 93% of cases.[9] Linear streaks of calcification will permit an assessment of the lesion in 86% of the cases. Gliedman found that 80% of 68 patients with symptomatic aneurysms were dead within a year.[10] Shapiro observed that untreated aneurysms over 7 cm. went on to rupture in 72% of 84 cases.[20] The mortality of ruptured aneurysms ranges from 25 to 30% in contrast to 5% in unruptured lesions.[14] The five-year survival rate of untreated symptomatic cases is about 10%.[10] It seems logical to conclude that all large or symptomatic aneurysms should be excised and grafted if the cardio-renal status is stable enough to warrant correction.

An evaluation of 107 cases of peripheral aneurysms involving the femoral, popliteal, axillary, and brachial vessels, by Crawford et al, revealed the unexpected occurrence of multiple lesions in 55% of the cases in contrast to 5% in which the aorta was aneurysmal. Resection and graft was advocated.[3]

Emboli to the extremities: Embolism is usually manifested by the sudden onset of excruciating pain in an extremity which rapidly becomes pallid, pulseless, and lifeless. Pre-existing atherosclerosis may be a feature of this problem. Frequently there is underlying heart disease characterized by a changing rhythm, myocardial infarction with fragmentation of mural clot, or bacterial endocarditis. Absent pulses in bilateral groins usually signifies an aortic embolus.

There is no conservative management for aortic, femoral or axillary emboli. About one half of patients will escape anatomical loss but few will avoid functional impairment of the extremities from embolism to the brachial or popliteal bifurcations. The embolus must be removed as soon as feasible for once clot has formed distal to the embolus it is difficult to restore circulation even with retrograde flushing. Extraction of the embolus, if overt gangrene is not present, should be attempted as late as 48 hours. It appears that the survival of the limb will depend upon the restoration of the blood flow rather than the use of anticoagulants or sympathectomy.

Dissecting Aneurysms: Dissecting aneurysms of the aorta are thought to occur from cystic necrosis of the media and hypertension. The transverse tear may be in the ascending arch or distal to the left subclavian artery. Pathological rents in the arch carry a high mortality from rupture into the pericardial and pleural cavities or cephalad dissection about the carotid vessels. In either type distal dissection may occlude the circulation of the bowel, kidney, or extremities.

The diagnosis is suggested by (1) a history of severe back pain, (2) central nervous system

symptoms, (3) differential pulses in the extremities, (4) widened aortic arch by X-ray, and (5) microscopic hematuria. Treatment is based upon the concept of recannulation of the blood flow into the aorta distal to the proximal tear. In cases of a rent in the ascending aorta, DeBakey advised transection of the descending aorta; obliteration of the two channels in the distal segment by over and over suture; crescent excision of the intervening media in the proximal segment; and re-anastomosis. In a tear distal to the left subclavian artery, he advised resection and graft.[5] This method would necessitate the use of a left atrio-femoral shunt in order to avoid uncontrollable hypertension.

Terminal thrombosis of the aorta (LeRiche's Syndrome) is observed in patients with gluteal claudication and impotency in he male. Differential pulses in the groins suggest incomplete aortic obstruction. In cases of incomplete occlusion an aortogram is vital. Complications of aortography such as renal failure, paraplegia, mesenteric occlusion, retro peritoneal infection, intraortic dissection, and drug sensitivity have been documented; but the risk of careful aortography seems less than the hazard of tackling the problem without knowledge of the terminal aora and the vascular bed of the extremities.

The lesion can be treated by excision and graft, by-pass graft, or thromboendarterectomy. Linton favors thromboendarterectomy.[12] DeBakey was able to restore flow in 95% of 448 cases of aorto-iliac disease followed for almost five years.[6] He prefers excision and graft but may employ any one of the methods of treatment.

Femoral Artery Occlusion: Intermittent claudication, ischemic ulcers of the feet, impending gangrene, and controlled localized gangrene of the toes in the presence of non palpable popliteal pulses suggest the need of an arteriogram and possible reconstructive procedures.[18] Claudication in the calf suggests a femoral-popliteal obstruction. The atherosclerotic lesions are frequently short and located at the adductor hiatus. If the obstruction is short, thromboendarterectomy is an excellent maneuver. Cannon advocated endarterectomy for both long and short occlusions,[1] but in longer obstructions it is difficult to strip out intima and media in calcified vessels. The ragged edges may lead to thrombosis. A long block in the femoral artery is probably best managed with a by-pass plastic graft using proximal and distal end to side anastomoses. An arteriogram is mandatory to determine the nature of the occlusion and the presence of a distal graftable vessel. Warren found only 9% of his arterial homografts and 18% of venous autografts, but 55% of thromboendarterectomized femoral vessels open at the end of two years. He considers the major hazard of thromboendarterectomy as suture line stenosis and fibrotic contracture of the wound. If the thromboendarterectomized vessel remained patent for six months, late success was apt to occur.[21] DeBakey was able to restore pulsatile flow in 85% of 317 patients with femoral occlusion due to atherosclerosis using the by-pass technique.[6] Linton's choices of procedure in femoral occlusive disease are in this order: (1) venous autograph, (2) thromboendarterectomy, (3) thromboendarterectomy plus short segment of venous autograft, (4) arterial homografts, (5) synthetic prostheses.[12] Morris has noted early success from grafting below the knee. He reported 76% function of by-pass grafts in 33 patients below the knee with a short follow-up period.[17]

Presently the subject of femoral-popliteal occlusion remains controversial. Only long term follow-up studies will solve the problem of the choice of procedure. In the interim we must employ any one or a combination of the above techniques to preserve life and limb.

Obliterative End Artery Disease: There appears to be a group of patients, especially diabetics, who present severe ischemic changes in the feet, who have palpable popliteal pulses and absent distal pulses or absent popliteal pulses with such poor distal run-off by arteriogram, that reconstructive surgery is not feasible. These are most trying problems to both the physician and the patient.

If rest pain is absent and infection is not a problem, one may resort to a lumbar sympathectomy. A sympathetic block should be done prior to sympathectomy for ganglionectomy is usually unhelpful in this group of patients. Simple elevation of thc head of the bed and meticulous foot care will often heal the ischemic ulcerations. The lesions that occur in

the presence of copious but well localized infection or gangrene will often respond to simple toe amputation. This is hardly the case in which the lesion is dry, very tender, and exudes only a thin sero-sanguinous type of drainage. Rest pain, coupled with this type of lesion, usually responds only to amputation proximal to the foot.[15]

Mesenteric Embolism: Until the report of the first successful embolectomy by Shaw and Rutledge in 1957, the treatment of mesenteric embolism remained a tragic sequence of events.[19]

The diagnosis is suggested by severe abdominal pain radiating into the back and a paucity of physical findings in the abdomen. An underlying cardiac problem is frequently found. During the later stages of this disease, blood is noted in the stools and vomitus. Abdominal tapping which is often conclusive in venous thrombosis is of little help in the early stages of arterial occlusion.

Exploration reveals little free fluid; the bowel has a gray, dull appearance; and no pulsations in the arteries are seen. If the absence of pulsation is confirmed by incising a distal vessel, the superior mesenteric artery is mobilized by elevation of the transverse colon and dissection medial to the ligament of Treitz. The proximal superior mesenteric artery is comparable in size to the common femoral artery. If there is occlusion of the proximal segment, the embolus can often be felt. Arteriotomy with removal of the embolus may result in good flow; if not, it may be necessary to add a thromboendarterectomy. Thromboendarterectomy becomes the treatment of choice if thrombosis is secondary to an atherosclerotic plaque. Re-exploration may be wise in 24 to 36 hours. This is applicable because, even though the mesenteric circulation is restored, there are apt to be patchy areas of gangrene in the bowel from clot in the small vessels. Spasm may be a prominent feature and may actually become irreversible. Adrenergic blocking agents such as chlorpromazine or dibenzyline should be given if spasm appears to be the cause of an impaired mesenteric circulation.

Impairment of Cerebral Circulation: Autopsy reports show that 30 to 40% of occlusions in cerebral circulation originate proximal to the skull. The symptoms of cerebral ischemia from vertebral obstruction are an unsteady gait, weakness, disorder of speech, and mental confusion. Carotid occlusion is suggested by the development of visual defects in addition to the aforementioned symptoms. A differential pulse in the upper extremities suggests involvement of the aortic arch.

Arteriography is essential to establish the site of the block. If the obstruction is proximal to the skull, surgical correction should be entertained.

The occlusion of the common carotid is most frequent at its bifurcation, whereas the vertebral is often obstructed at its origin. Incomplete obstruction is the most amenable to treatment. If the segment of the carotid occlusion is long but there is adequate back flow from the distal vessel, a by-pass graft from the subclavian to the internal carotid, after the method of Lyons and Gailbrath, is elected.[14] Crawford has applied thromboendarterectomy to stomal occlusion of the vertebral artery.[4] Cate and Scott reported relief of cerebral ischemia by endarterectomy of the subclavian and vertebral arteries.[2] Mention is made of the hazard of arteriography but if the mortality rate is to be improved, the risk must be accepted.

Hypertension from Renal Artery Stenosis: The correct evaluation of hypertension rests heavily upon the internist. Distinction must be made between hypertension from parenchynal renal disease which has a poor prognosis and elevation of blood pressure from extrinsic renal factors which may carry an excellent outcome. Coarctation of the aorta and pheochromocytoma must always be considered.

Elevation of blood pressure from occlusive disease of the renal arteries is most common in individuals under 25 years of age (from congenital renal artery stenosis) and in patients over 50 years of age (where atherosclerosis is a major factor). Patients with arterial stenosis demonstrate only subtle changes in urinary function. The routine renal function tests including intravenous and retrograde pyelography are usually unhelpful. The most worthwhile diagnostic tool is aortography. Aortography is suggested in the following group of hyperten-

sive patients: (1) patients under 25 years of age with hypertension, (2) patients with hypertension who do not respond to medical treatment, (3) patients who develop hypertension following an attack of flank pain (suggests renal infarction), and (4) patients with preexisting hypertension whose hypertension suddenly becomes worse.

Long standing unilateral occlusion of the renal vessels may require a nephrectomy if the kidney is atrophic or the vessels are unsuitable for reconstructive procedures. The involved kidney may be less abnormal than its companion since it has not been subjected to the sustained effects of hypertension. Consequently it behooves the surgeon to make every effort to preserve the ischemic kidney. DeCamp and Birchall have advocated spleno-renal arterial anastomosis.[7] Leadbetter suggests the use of a patch homograft which maintains the natural funnel union of the renal artery with the aorta.[12]

Summary and Conclusions

A brief summary of the current management of arterial injuries and atherosclerotic lesions is presented. A satisfactory outcome appears to depend upon the early recognition of the vascular problem and its correction.

It would seem that as people live longer, vascular problems will become more numerous. We must be prepared to deal with the coronary, renal, mesenteric, and cerebral circulations as well as aortic and extremity occlusions.

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Attend the . . .

PRESIDENT'S LUNCHEON

Wednesday, September 23

A High Point of the 1959 Annual Meeting

Conservative Versus Definitive Approach to Benign Tumors of the Uterus

Laman A. Gray, M.D.*

Louisville, Ky.

"Benign tumors of the uterus" refers mainly to myomas of the uterus. These extremely frequently occurring, almost completely benign tumors, have been estimated to occur in from fifty to one hundred per cent of all women, at least to a small degree.[1] Clinically twenty to twenty-five per cent of patients have myomas of the uterus. Various approaches to the problem of myomas of the uterus include observation, curettage and observation, hysterectomy, and myomectomy. The majority of women with myomas of the uterus have no symptoms, and perhaps only one-fourth have any symptoms requiring treatment. One surgeon may advise great conservatism, another may advise myomectomy frequently, still another may perform hysterectomy at the very mention or discovery of a small myoma. Finally there is an approach to the problem from its various angles.[2]

Observation of Myomas

In this report, patients having myomas observed have totaled 215 cases. The age of these patients has ranged from twenty to seventy, the largest number being between forty and forty-five, where there were fifty-two. The myomas in these cases were of varying size. Those approximately one and one-half times the size of the normal uterus numbered sixty-seven; of those nodular tumors fully two times the normal size of the uterus, there were seventy; of those three times the normal size and quite nodular, there were fifty-three; of those the size of a three month's pregnancy or larger, there were twenty-one. These patients were observed up to ten years. Forty-six were observed one year, eighteen for two years, sixteen for three years, sixteen for four years, eleven for five years, eight for eight years, and five for ten years.

TABLE I

Complaints—215 cases observed with myomas

Menometrorrhagia	60	Irregular	5
Pain	30	Backache	5
Nervous	25	Soreness	4
Tumor	22	Itching	4
Cramping	16	Headaches	3
None	14	Tired	3
Discharge	10	Bladder	3
Sterility	6	Hot flashes	2
Pressure	6	Indigestion	1

The complaints of these 215 observed patients included all of those that may be seen with the ordinary myoma cases. The most frequent complaint was of meno-metrorrhagia in sixty patients. This menorrhagia was of slight to moderate degree and the irregularity was not marked. With any marked irregularity, curettage was performed or was advised. Certainly this was true of intermenstrual bleeding. Pain occurred in thirty of these patients as a prominent complaint. The next complaint in the order of frequency was nervousness, involving twenty-five patients, obviously not produced by the tumors. Twenty-two patients complained of a tumor, having been told that they had a tumor that needed operation. A main complaint of cramping with menstruation, and occasionally between menstruation, occurred in sixteen patients. Fourteen patients had no complaint whatever, and the tumors were found on routine examination. Ten patients complained of a vaginal discharge, again related to vaginitis or cervicitis, and having no relation to the myo-

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mas. Sterility was a prime complaint in six patients. Pressure was a main complaint in six others. Irregular menstruation, as oligomenorrhea, or more frequent menstruation, though of normal character otherwise, occurred in five patients. Backache was a chief complaint in five patients, soreness in four, itching in four, headaches in three, tiredness in three, bladder frequency in three, hot flashes in two, and indigestion in one. It is obvious that a number of these complaints could not be related to the myomas of the uterus and that they were incidental.

A follow-up of these patients is of particular interest. Of the 215 patients, 120 have been followed for one to ten years. The other ninety-five have not returned for follow-up examination, although all were urged to do so. Undoubtedly many of these patinets came for a single opinion to corroborate or to vary from that of their own physician. Undoubtedly many of them have had hysterectomies because of a difference of opinion, because of their fear of tumor and cancer, or because of the personal impression of the proper treatment. Of the 120 patients, twenty-four had curettage of the uterus and biopsy of the cervix for irregular bleeding; all of these were benign. Testosterone was used in two patients to decrease menorrhagia. Pregnancy occurred in thirteen of the 120 patients, and this is considered a fortunate achievement, at least by the gynecologist. All but one in this group had normal vaginal delivery. The menopause followed in ten patients, removing the problem of bleeding, and always being followed by decrease in the size of the tumor. Subsequently, because of irregular bleeding, curettage was advised in ten patients. Hysterectomy was advised, because of increased menorrhagia and progressive increase in size of the uterus, in ten patients, and in sixteen others hysterectomy was considered, both by the patient, and by the gynecologist.

As is well-known, and as is demonstrated from this group of patients, small myomas of the uterus with minor symptoms may be observed through a period of years and often into the menopause without the necessity of hysterectomy. On the other hand, as time passed, in this small group of patients, thirty per cent were advised to have either curettage or consider hysterectomy. Undoubtedly still others over a longer period of time will require definitive therapy.

TABLE II

Hysterectomy for Myomas

TOTAL CASES	263
Large size	128
Pain	42
Bleeding	93
Unsuspected sarcoma	7
Unsuspected ca.-in-situ	1
Unsuspected early adenoca. cervix	1
Post-op. complaints	41

Hysterectomy for Myomas

In a second group of 263 patients hysterectomy was performed. There were three main indications: *large size* in 128 cases, *pain* in forty-two cases, and *hemorrhage* in 93 cases. In all three of these groups there was often abnormal bleeding or degrees of pain associated with the large size which alone might indicate hysterectomy. In each instance the most prominent complaint was used to classify these patients. Of the 128 patients who had hysterectomy for *large size,* the uteri were larger than a three months pregnancy, often filling the true pelvis, the lower abdomen and even extending into the upper abdomen. Ordinarily the mere presence of a tumor of such size is sufficient reason for removal, unless the patient is a poor risk, is psychologically unprepared, or prefers to have the tumor observed. Twenty-three of this group had menorrhagia of such degree that this complaint alone might have been an indication for hysterectomy, but the size seemed so prominent that these cases were listed in this category. One hundred and fourteen of the patients were followed from three months to thirteen years, the majority longer than one year, and were considered to have good results. Two were not followed, and twelve had various complaints. These complaints included nervousness, dizziness, pelvic pain, and backache. One had shock therapy before operation, with repetition several times afterwards. This is a small percentage of poor results. It includes the inadequate individuals with problems who might be helped by reassurance. Since the size of the tumor was usually obvious, the functional results rarely were disappointing. Three of these patients had unsuspected sarcomatous change in myomas, and one had unsuspected carcinoma-in-situ of the cervix.

The hysterectomies were performed because of marked *pain* in forty-two patients. In each instance the myoma was large enough to cause pain from pressure against the lateral wall of the pelvis from extension beneath the bladder, against the other pelvic viscera, or to be associated with incapacitating dysmenorrhea. Twenty-nine patients had a good result. Thirteen subsequently complained of nervousness. All but four were relieved of their pelvic pain. One patient became more depressed and committed suicide one year later. This latter patient had mild to moderate agitated depression prior to the operation, and it was doubtful the procedure affected the outcome. One early and unsuspected adenocarcinoma of the cervix was found.

Myoma accompanied by profuse *bleeding* was the indication for operation in ninety-three patients. Menorrhagia was the prime complaint, usually being reflected by some degree of secondary anemia. The myomas were of sufficient size to produce an obviously much enlarged uterus. There were numerous other pelvic lesions in this group, but while important, they were asymptomatic or were over-shadowed by the presence of the tumor and profuseness of the bleeding. Three patients who had unsuspected sarcomas in myomas, were well two, three and six years later. Seventy-six had good results and no complaints.

Of the sixteen patients with complaints who were operated on because of profuse bleeding, five had nervousness with no clearly ascribed reason. Another had pruritus vulvae, one backache, and one exhaustion. Various other nervous complaints occurred in this group. One patient developed a manic psychosis in the postoperative period; she and her family had carefully withheld information of previous manic depressive episodes with repeated shock therapy. All patients had good anatomical results.

Hysterectomy for "Combined Syndrome"

An entirely different group of patients, who have myomas not producing the main symptom, but being a part of the symptom complex, has been named the "combined syndrome." This is a combination of multiple organic abnormalities in the pelvis associated with multiple positive and distressing related symptoms which summate to a major disability. The findings alone do not necessitate hysterectomy unless there are severe symptoms. In this group we have analyzed 277 patients. Vaginal outlet relaxation, cystocele or rectocele, at times enterocele, descensus of the uterus of first or second degree, and retroversion of the uterus may be placed together and are commonly related to a basic part of the syndrome. In addition to these relaxation findings, myomas were present in 126 (45.4 per cent) of this group of 277 patients. These tumors did not have any of the three strict indications for hysterectomy solely for the myoma, namely large size, profuse bleeding related to the tumor, and pain related to the pelvic tumor. On the other hand, these multiple smaller fibroid tumors added to the dysfunction, weight, pressure symptoms, and prolapse of the uterus, and were definite additive factors in these particular cases.

TABLE III

Hysterectomy for "Combined Syndrome"

TOTAL CASES	277	
Myomas	126	(45.4%)
Relaxed outlet	165	
Rectocele	140	
Cystocele	54	
Descensus 1st degree	85	
Descensus 2nd degree	14	
Retroversion	98	
Subinvolution	73	
Fibrosis	11	
Cervicitis	230	
Ca.-in-situ cervix	2	
Malignant polyp	1	
Ca. ovary early	2	
Ca. cervix early	1	
Post-op. complaints	26	

In addition to relaxation and myomas in the combined syndrome, other organic findings, associated with symptoms, are present. These include cervicitis, subinvolution, fibrosis, various hernias, adenomyosis, cervical and endometrial polyps, salpingitis of mild degree, pelvic endometriosis of mild degree, cystic and solid changes in the ovary, as the dermoid cyst and fibroma of the ovary, and occasionally the other smaller benign and malignant neoplastic cysts. Menorrhagia, metrorrhagia, dysmenorrhea, and vague but disabling pelvic pains are symptomatic portions of this syndrome. Two hundred and fifty of these patients are considered to have a good result, and 168 were followed from one to fourteen years. A more detailed review of twenty-seven patients with not the best results seems justified. One died of pulmonary embolus. The main complaint of the

others was nervousness. Most of them had been quite nervous before operation. One was anxious over the marriage of a daughter below her social standing; two were involved in constant family upsets; one worried much over her children; one was preoccupied over finances; three becamed divorced; another had a paranoid husband; one complained of dyspareunia. Six complained of abdominal pain and two of exhaustion. One was not certain whether she was improved. Various other emotional difficulties, apparently related not to the hysterectomy, but to problems of life, occurred in the remainder of this group of twenty-six.

Even these complaining patients were really improved in our opinion. Nervous people may have organic difficulties, but nervousness cannot be removed by operations. The patients should understand this, but evidently thorough preoperative explanations may not be remembered. It is in this group of "combined syndrome" of symptoms and multiple gynecological abnormalities that misjudgment is likely to occur. It is here that the most accurate diagnostic skill is necessary. Poor psychological results after surgery for malignant disease or very large tumors are largely ignored because the operation seemed mandatory, but poor results in those occur just the same. Careful explanations are most important. In this latter series of patients, two early carcinomas of the ovary and two carcinomas-in-situ were found unexpectedly in the study of the excised tissue. In addition there was one malignant endometrial polyp.

In this series of 389 hysterectomies containing myomas, sarcoma in a myoma was reported by the pathologist in seven patients (1.8 per cent). An additional postmenopausal patient, during this period of time, has been operated upon with a pre-operative diagnosis of sarcoma of the uterus. There was marked enlargement and fixation of the uterus, associated with postmenopausal bleeding. After complete operation, recurrence and metastasis was followed by death. However, of the other seven sarcomas incidentally found in myomas, all are living and well following hysterectomy. These are evidently rather mild degrees of malignancy as compared with the very anaplastic and rapidly spreading tumor.

Myomectomy

The next approach to the most frequently occurring benigh tumor of the uterus, the myoma, is myomectomy. This operation has had enthusiastic proponents at intervals in the literature. Probably the most enthusiastic was Bonney, who developed the operation of multiple myomectomy primarily for sterility. By 1937 he had performed 632 myomectomies. In one case he removed 140 myomas, in another over 200 myomas. A special clamp was devised by Bonney to fit around the lower uterine segment to control bleeding during the process of this multiple and extensive operation. Brown, Chamberlain and TeLinde[3] reported 355 cases with myomectomy in a twenty-one year period, of which eighty-eight were vaginal myomectomies and 247 were abdominal operations. Sixteen were operated on during pregnancy and eleven went to term. Of 176 patients with myomectomy followed five years or more, fifty-five or 31.3 per cent had recurrence. Thirty-seven had hysterectomy. Because of the recurrence of myomas, which has been the experience of the majority of gynecologists, the tendency has been not to press the operation beyond ordinary expectations.

In my experience the majority of cases having myomectomy have been associated with pelvic endometriosis. In these cases the operation was performed primarily to relieve infertility, in addition to pelvic pain and discomfort in quite young women. In a series of 200 cases,[4] operated on for endometriosis, myomectomy was done in thirty-one patients. Usually

TABLE IV

Myomectomy in Conservative Operation for Endometriosis

TOTAL CASES	200
Myomectomy	31
Unilateral oophorectomy	63
Resection one ovary	59
Resection both ovaries	17
Excision implants	122
Subsequent pregnancy	57

these included multiple myomectomy, two, three or four tumors being removed. In this series of 200 conservative operations for endometriosis, 15.5 per cent had myomas. In another series of advanced endometriosis, myomas occurred in more than one-half the cases. Of these 200 conservative operations, 153 were

in married women; fifty-seven of these or 37.2 per cent subsequently conceived. Six of these 200 patients have had subsequent radical operations, and a number of others will necessarily require radical surgery in the future. Myomas had recurred in the six with second operations, and in several others myomas are palpable.

In addition, in young women, primary myomectomies were performed sporadically. In rare instances a sizable single myoma, deeply placed in the myometrium, and even extending into a submucous position, has been removed in quite young women with severe menorrhagia, which has been followed by excellent results over a few years observation. Large subserous tumors, which are pedunculated, are removed on occasion.

The occurrence of sarcoma in myomectomy specimens has been reported by Laustadt and Javert[5] as five cases occurring in 690 myomectomies. Others have reported occasional sarcomas in smaller series. It appears that the incidence of sarcoma in the myomectomy specimens is so low as not to be a factor in the consideration of this operation. On the other hand, the incidence of recurrence is a real one, and probably approximates at least fifty per cent of cases that are operated on if they are observed over a sufficient period of time. For this reason, it would seem logical to avoid myomectomy until or unless hysterectomy is obviously necessary. In occasional instances, myomectomy may be indicated for sterility, but, in my opinion, this is not an operation for wide use.

Myomectomy in Pregnancy

Myomas are found in three or four per cent of pregnant women, of sufficient size to be quite obvious and often to cause marked symptoms. These tumors during pregnancy are particularly prone to cause severe pain, apparently because of degeneration or hemorrhage into them. Also they cause discomfort from pressure on surrounding organs and nerve trunks. Myomas may be a cause, or associated cause, of abortion. Certainly they may cause dystocia and interfere with the normal mechanism of labor by producing uterine inertia. Post-delivery hemorrhage and other complications may occur on occasion. Lusk[6] has reported twenty-two patients with significant myomas in a series of 631 pregnant patients. Three of these patients had antepartum myomectomies, two postpartum myomectomies, and three had subsequent hysterectomies. Threatened abortion, and painful degeneration were not infrequent, and in one instance, in the third trimester, acute degeneration of a myoma caused an acute surgical abdomen. More complications are to be expected, including antepartum bleeding, pain, antepartum surgery, increased operative deliveries and higher postpartum morbidity. Sosnowski[7] reported three patients having myomectomy, two being during pregnancy, with subsequent Caesarian section in one and spontaneous delivery in the other.

In my experience, myomectomy has been performed during pregnancy in six patients. Two patients were eight weeks pregnant, two patients were ten weeks pregnant, one patient was twelve weeks pregnant, and one patient was sixteen weeks pregnant. The first five patients had myomectomy performed without interruption of the pregnancy and with subsequent delivery of a normal child, three by

TABLE V

Myomectomy during Pregnancy

TOTAL CASES		6
Duration pregnancy	8 weeks	2
	10 weeks	2
	12 weeks	1
	16 weeks	1
Term pregnancy		5
Abortion		1

Caesarian section and two by normal delivery. The findings at operation included in one, a firm tumor 8 cm. in diameter, deep in the posterior wall of the uterus; the second, a pedunculated myoma 8 cm. in diameter with a broad pedicle 3 cm. in diameter; the third, a large myoma in the left cornu 9 cm. in diameter; the fourth, a large tumor 11 cm. in diameter, deep in the anterior wall of the uterus; and finally in the fifth, a tumor in the wall of the uterus some 7 cm. in diameter. These patients were complaining of moderate pelvic discomfort, more than that associated with normal pregnancy, the nature of the tumors was not clear (one pedunculated tumor was thought to represent an ovarian tumor), and it was obvious in two or three that normal delivery would be impossible. In two cases the large myoma extended down to the endometrium, which was bared over a relatively large area; a

careful closure of the wall of the uterus in layers was followed by no miscarriage. One of the latter patients had a normal vaginal delivery, although one would have thought the danger of rupture to be very great. These patients were operated on for the most part before the twelfth week of pregnancy. I would not hesitate to perform an operation on either the ovary or uterus as early as the indication appears. In the sixth patient, the pregnancy was of approximately sixteen weeks duration and there had been associated marked abdominal pain, cramping and vaginal bleeding. The operation was quite traumatic because of an unusually large tumor, some 15 cm. in diameter with a broad involvement of the uterine wall. It is evident that the patient was already in a stage of abortion and that this was to be expected. Subsequently this particular patient conceived and was delivered by Caesarian section. It appears that if the patient shows no evidence of threatened abortion, that operations on the uterus, if performed with great care and gentleness, may be successful and not produce an abortion. As a rule, myomas during pregnancy are observed, and operations are performed only if the symptoms are severe or the diagnosis inconclusive.

Myomectomy at Caesarian Section

In my experience a total of four patients have had myomectomy performed at the time of Caesarian section. In subsequent years myomas have recurred in three of these patients, and two have had subsequent hysterectomies.

TABLE VI

Myomectomy at Caesarian Section

TOTAL CASES	4
Recurrent myomas	3 cases

Adenomyosis

The conservative surgical approach to adenomyosis of the uterus offers relatively little hope for the average case. The diagnosis of this disease is largely dependent on symptomatology, but this is never conclusive. Apparently some fifteen per cent of cases of adenomyosis may be diagnosed by careful technique with the hysterogram, in which the contrast media may enter the minute glands extending in the wall of the uterus. This disease is most often diffuse, extending around the entire endometrial cavity so that excision seems utterly impossible. On occasion, the adenomyosisis more localized, producing a nodule that well may be termed the adenomyoma, and on such occasion, excision is possible. This has been performed twice in my experience, and undoubtedly could be performed more frequently if there seemed an important reason to leave the uterus in place at the time of abdominal operation. The probability of incomplete removal of this adenomyosis tissue, the probability of recurrence of symptoms, which were severe enough to necessitate abdominal operation, makes it illogical to leave the uterus in situ under such symptomatic circumstances. Perhaps adenomyosis is a factor in sterility, but this is largely unknown. Certainly pregnancies do occur in the presence of adenomyosis of the uterus.

Stromal myosis

This rare disease is diagnosed with difficulty. It may be diagnosed during hysterectomy when worm-like strands of tissue may be noted in the enlarged lymphatics and broad ligaments, or after the excision of the obviously tumorous uterus and its inspection after bisection. Then again the worm-like portions of tumor may be drawn out of the muscular wall. In perhaps fifteen or twenty per cent of cases the tumor is malignant. It is difficult to see how one could approach this disease in a conservative manner.

Summary and Conclusions

1. A study of 645 cases with myomas of the uterus revealed that:

a) Observation was advised in 215 cases. Twenty-four had diagnostic curettage of the endometrium and biopsy of the cervix. One hundred and twenty were followed from one to ten years. Subsequently ten patients have been advised to have curettage, and in twenty-six the size and symptoms of the tumors have progressed to such a degree that hysterectomy is to be considered.

b) Hysterectomy was performed in 263 cases for strict indications from the myoma itself, 128 for large size, 42 for pain, and 93 for hemorrhage.

c) Hysterectomy was performed in 126 cases with myomas as a factor (45.4 per cent) in the "combined syndrome," a combination of multiple organic abnormalities in the pelvis associated with multiple positive and distressing related symptoms which summate to a major disability.

d) Myomectomy was performed in 31 of 200 cases with conservative operation for endometriosis.

Myomectomy was performed in 6 cases during pregnancy (one abortion in progress completed).

Myomectomy was performed in 4 cases at Caesarian section.

2. Smaller myomas with insufficient direct symptoms may be observed. Many will progress to the menopause and not require hysterectomy.

3. Myomectomy is indicated when the symptoms and findings require operation during pregnancy, incidentally at Caesarian section, when the operation primarily is for endometriosis, and on occasion in young women with severe bleeding, marked pain or sterility. The recurrence rate appears high. Ordinarily, observation is indicated until sufficient time, increase in size, and marked symptoms have progressed to necessitate hysterectomy.

4. Malignant lesions are uncommon though not to be discounted, occurring in three and four-tenths per cent of excised specimens in this series. Incidental histologic sarcoma occurred in seven cases, and all have remained cured. Other early malignant lesions were found incidentally in eight cases.

5. Adenomyosis and stromal myosis are difficult of diagnosis before microscopic study of the specimen. Being diffuse in nature, they rarely may be treated by conservative operations.

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Be Sure to Read . . . . . .

PROTOCOL—CLINICOPATHOLOGIC CONFERENCE

on pages 1076-77

Pheochromocytoma:

Its Diagnosis and Treatment*

MARTIN H. BOLDT, M.D.**

Louisville, Ky.

CLINICAL hypertension due to pheochromocytoma is an uncommon condition said to occur in about 0.5% of all cases of hypertension. On this basis it is estimated that between 600 and 800 people die annually from this cause. These deaths are preventable because the hypertension due to this tumor is curable. In spite of this there are probably more unrecognized deaths annually from this ailment than there are case reports in the literature.

Pheochromocytomas are functioning tumors of chromaffin tissue usually located in the region of the adrenal glands. By functioning tumors we mean they elaborate pressor amines, epinephrin and norepinephrin. In about 15% of the cases they occur in other locations along the aorta. In almost one fifth of all cases they are multiple and about half of these are bilateral. Between 5% and 10% are malignant.

The Clinical Picture

The clinical picture due to pheochromocytoma appears in many forms: Notably, hypertensive vascular disease, hyperthyroidism, diabetes mellitus, toxemias of pregnancy, psychoneuroses and others.

The hypertension may be paroxysmal or persistent. Statistically the persistent form predominates. Wide fluctuation in blood pressure occurs in both forms. The persistent form may closely mimic chronic hypertensive disease—even malignant hypertension. The paroxysmal form is characterized by "attacks" or "seizures" during which there is an abrupt rise in the blood pressure. The release of the hormones, epinephrin and norepinephrin, to the circulation is responsible for the varied clinical manifestations of pheochromocytoma.

There are a number of clinical clues which should make one suspect a pheochromocytoma.

1. "Seizures" or "attacks" characterized by headaches, palpitation, dyspnea, weakness, chest or abdominal pain, nausea, vomiting, flushing, pallor, dizziness, nervousness, blindness, tingling and convulsive twitching particularly when accompanied by paroxysmal rise in blood pressure.

2. "Seizures" precipitated by emotional disturbance, change of body position, abdominal palpation or following the administration of histamine for gastric analysis, or as the result of trauma of various sorts including surgical manipulation and anesthesia.

3. Hypertension in any young individual or a rising blood pressure early in pregnancy suggesting toxemia.

4. Hypertension associated with fever, unexplained sweating, glycosuria, hyperglycemia, hypermetabolism or neurofibromatosis.

Physical examination often fails to disclose information of diagnostic value. Since an abdominal tumor is palpable in 14% of cases, pressure in both flanks or massage of the tumor, if palpable, should be done routinely in order to precipitate an attack. Should an excessive hypertensive response occur, then Benodaine® or Regitine® should be administered intravenously. The immediate blockade of this

*Presented at the annual postgraduate medical seminar of the Norton Memorial Infirmary, Louisville, on December 18, 1958.

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excessive hypertensive response is evidence that the blood pressure rise is caused by epinephrin or norepinephrin.

During a paroxysmal "seizure," peripheral vasomotor phenomena, such as mottling of the skin, pallor, excessive sweating, constriction of the fundal arteries, and even disappearance of the radial pulse, have been observed. A rise in body temperature and in the blood sugar level is sometimes also seen.

Other Aids to Diagnosis

Diagnosis of pheochromocytoma can seldom be made on clinical grounds alone. Additional procedures are available to help clarify this diagnosis and these include x-ray studies, pharmacologic tests, and a determination of catecholamine in the blood and urine.

Attempts should be made to visualize a pheochromocytoma by various x-ray studies including flat plate of the abdomen, pyelography, laminograms, perirenal air injection, and presacral air insufflation. A tumor is infrequently demonstrated by these techniques. Occasionally downward displacement of a kidney may be demonstrated.

Pharmacologic tests for pheochromocytoma are divided into two groups: The provocative and the adrenergic blocking procedures. The former or provocative agents depend upon stimulation of chromaffin tissue to deliver epinephrin and norepinephrin to the circulation in excessive quantities. The agents commonly used are histamine, Etamon® and Mecholyl,® with histamine being the preferred agent. The adrenergic blocking procedure utilizes drugs which neutralize the effect of circulating epinephrin and norepinephrin. Commonly used agents are Regitine and Benodaine, and it has become the tendency lately to reserve Benodaine as a confirmatory agent for Regitine.

The pharmacologic tests for pheochromocytoma have many shortcomings. "False" positive and "false" negative results have been obtained with both the provocative and adrenergic blocking agents. Furthermore, individual patients may give positive results to one of these agents and react negatively to another agent in the same class of drugs. Additionally, some patients may react positively or negatively to a particular agent on one occasion, and give the opposite reactions when re-tested. Finally, all these agents are capable of eliciting adverse and at times alarming reactions in patients with pheochromocytoma and also in those with hypertension from other causes.

To minimize the incidence of "false" responses, pharmacologic tests should be performed only after the patient has rested in bed for 15 to 30 minutes to insure stable, controlled blood pressures. All sedative and antihypertensive drugs should be discontinued for at least 48 hours prior to testing to avoid "false" positive and "false" negative results. After administration of a drug, observation should be continued for at least 15 minutes so as to minimize the effect of blood pressure fluctuations from other causes. "False" negative responses after the use of a provocative agent may result from sedation, antihypertensive medication, high initial levels of blood pressure or too slow an injection of a test agent. Excessive amounts of histamine (0.15 mg.) may cause a "false" positive result.

The adrenergic blocking agents are useful primarily in those patients with persistent hypertension at levels about 170/110 mm. Hg. During periods of normal blood pressure, when humoral secretion of epinephrin and norepinephrin is relatively low, blocking agents have no diagnostic value. "False" negative results may occur when controlled blood pressures are too low, when there is hypertension from some other cause (which may co-exist with pheochromocytoma) or during administration of antihypertensive medication. "False" positive results have been obtained in patients who have received sedation, or in patients with uremia and also for reasons which have not been determined.

Untoward reactions, especially cardiac arrhythmias and hypertensive responses have occurred from the use of all of these pharmacologic agents. The pharmacologic tests are most useful if carefully applied. Where indicated, a patient suspected of having a pheochromocytoma should be subjected to a battery of these tests before one comes to a diagnostic decision.

More recently a quantitative test for catecholamines in blood and urine has been developed. Epinephrin and norepinephrin are catecholamines. These are tedious tests to perform but are run routinely by a number of laboratories in the country. There is no risk to the

patient, and "false" positive results have been reported infrequently. Anxiety may be associated with moderate elevation catecholamine levels. The incidence of positive results in cases of pheochromocytoma approaches 100% and is higher than those obtained with the use of the pharmacologic agents. Usually a 24-hour urine specimen or a specimen of urine voided during a period of hypertension, or soon after an "attack," is examined. There have been some studies on blood which have demonstrated a rise in catecholamine during or after an "attack."

Treatment

The treatment of pheochromocytoma is surgical removal of the tumor or tumors. Since this is not in the category of emergency surgery, the patient should be in optimum condition for surgery. Surgical management involves teamwork between the surgeon, the anesthetist and the internist. There are three special dangers associated with this surgery:

1. Anesthesia may provoke a hypertensive response. Avoid hypotensive anesthesia.

2. Surgical trauma and especially manipulation of the tumor during surgery may squeeze epinephrin and norepinephrin from the tumor into the circulation and precipitate an "attack" and at times also cardiac arrhythmias.

3. Commonly when the tumor pedicle is clamped off there is a precipitous fall in blood pressure to shock levels.

Since pheochromocytomas are multiple in 20% of the cases and bilateral in about 10%, a transabdominal approach is preferred to allow the surgeon to examine the abdominal para-aortic region in its full course. The surgeon should handle the viscera carefully, remembering that manipulation of a pheochromocytoma may precipitate an "attack." Adrenergic blocking agents such as Regitine should be available should a hypertensive response ensue; however, these agents should not be used unless necessary, because the much commoner complication is shock occurring as soon as the tumor pedicle is clamped. Should shock ensue, the blood pressure is supported with an infusion of Levophed® as long as necessary.

As soon as the tumor is removed, a hypotensive response is the rule. The surgeon should wait 15 or 20 minutes before starting surgical closure to ascertain that a secondary hypertensive response does not occur. Should this happen the surgeon should look for and find a second or more tumors; remember—pheochromocytomas are multiple in about one fifth of cases.

Twenty-four to forty-eight hours postoperatively, hypertensive blood pressures may be persistently observed. This usually does not mean a pheochromocytoma has been missed at surgery. Hypertension in cases of pheochromocytoma may outlast the presence of pressor material in the blood for weeks. It is probable that this persisting hypertension is due to the development of arteriolar lesions secondary to the epinephrin- and the norepinephrin-induced hypertension. Following removal of the tumor, these arteriolar lesions clear and so does the accompanying hypertension.

A most rewarding experience awaits the physician who makes a diagnosis of pheochromocytoma and sees the patient through a successful surgical cure. Remember, it is the prepared mind with a high index of suspicion that makes this diagnosis.

Visit The Scientific Exhibits

During KSMA Annual Meeting

September 22-24

Radiation Hazards From Medical And Dental Uses Of X-Ray*

James B. Douglas, M.D.**

Louisville, Ky.

THERE is widespread interest among our patients, the general public, and the medical and dental professions in this problem. It is hoped that a review of the current literature and a presentation of the evaluations and recommendations of the American College of Radiology might be of interest and of value.

I would like, very briefly, to mention some of the reports which stimulated this current interest.

Reasons for Current Interest

The dawn of the Atomic Age required thoughtful consideration as to safeguards for personnel and the general public and efforts to determine acceptable radiation dosages for individuals and for the entire population. The report of the subcommittee of the National Academy of Science[1] indicated that radiation exposure from medical and dental uses of X-ray was sizable in relationship to naturally occurring background radiation and radioactive fallout. It was estimated that the average person living in the United States would receive gonadal radiation during the first 30 years of life of from 3.0 to 3.5 r depending upon the altitude, the type of habitation and other factors. Exposure from radioactive fallout was already 0.1 r and if weapons testing continued at the then present rate, might increase to 0.2 r. Exposure from medical diagnosis and therapy was estimated to be 4.5 r for this 30-year period or 59% of the total.

The incidence of leukemia in survivors of the atomic blasts near the hypocenters of Hiroshima and Nagasaki was 12 times that in survivors at the periphery of the blasted areas.[2]

An increase in the incidence of leukemia was reported in persons in Britain who had been treated for spondylitis by X-ray.[3] Actually, the number involved was not great, being 25 cases over a 20-year period out of 13,352 patients treated as opposed to an expected incidence of 2.4 cases. The doses commonly used in this group were greater than those ordinarily used in such cases in this country at the present time.

Development of cancer of the thyroid and of leukemia was reported in children who had been treated by X-ray for enlargement of the thymus.[4] Here the change in incidence is not marked in most groups of cases, some of the doses used were quite large, and this type of treatment is not being given ordinarily in this country any longer.

There was a reported increase in the incidence of leukemia below the age of 10 in children whose mothers had been X-rayed during pregnancy.[5]

Reports such as these naturally raised questions as to possible hazards from medical uses of radiation.

In this connection I would like to quote Dr. Edith Quimby who is one of the most respected radiation physicists in this country.

"The very important difference between the possible somatic or body damage caused by radiation exposure to the individual and the possible damage to the reproductive cells of the race (genetic damage) has not been made clear. Thus persons beyond the child bearing age have no need to be uneasy about any kind or any number of radiological examinations considered necessary by their doctor.

*Presented at the annual postgraduate medical seminar of the Norton Memorial Infirmary, Louisville, on December 18, 1958.

**Associate in radiology, University of Louisville School of Medicine.

Dr. Quimby continued,

"In people of this age group there are no somatic or body damages from any of the X-ray examinations performed by the radiologist, but for all patients, old and young, your radiologist takes special care to keep the radiation exposure to an absolute minimum by proper utilization of protection techniques already available."

Experimental work on some lower forms of life has made many geneticists apprehensive that a continued increase in man-made radiation might have serious effects upon future generations.[6] At the present time the exact quantitative levels at which certain effects may take place is not known; however, there are some things which are generally agreed.

Generally Accepted Opinions

Radiation effects upon the reproductive cells are believed to be cumulative, irreversible, and delayed. It is the total dose to the genetic pool of the population rather than the dose to the individual which is important in this respect. One hundred r to one person would have the same effect as one r to one hundred persons. The vast majority of radiation induced mutations are likely to be undesirable, probably in the range of 98%.

It is suspected that mutations in future generations would probably be in the nature of decreased resistance to disease, shortened life span, decreased vigor, increased tendency to allergies, and possibly some increase in mental defectives and some of the other more serious congenital anomalies.

The National Committee on Radiation Protection recommends that exposure from man-made radiation be kept below 10 r for the first 30 years of life. This does not mean that this dosage is desirable, and every effort should be made to keep the exposure as far below this level as is possible while still making use of the great benefits of radiation.

Thinking in these terms it obviously makes a great difference who is being X-rayed. Young adults under thirty should be considered particularly since they will be the parents of the majority of the next generation. Pregnant and potentially pregnant women should be guarded because of the hazard of double exposure. The fetus receives total body irradiation during procedures directed at the lower abdomen and pelvis. There are some indications that a fetus may be more sensitive during the first three months of gestation.

Infants and children deserve particular care. Their longer life expectancy and procreative potential make both somatic and gonadal exposure a consideration. Due to their small size and unpredictable movements, shielding and localization of exposure are particularly difficult.

Radiation exposure obviously may vary greatly for any procedure depending upon the equipment and the skill and interest of the person responsible for the examination. I would like to give some account of the gonadal exposures which have been measured in some of the best medical centers.[7] Under good conditions dental films and examinations of the skull and extremities should necessitate nothing more than the most minute gonadal exposure. A posteroantero film of the chest would result in an exposure of only 1/4 of a milliroentgen. A complete gastrointestinal series may result in from .15 to .3 r exposure to the testes and from 1.0 to 2.0 r to the ovaries. Pelvimetry may give from 2.0 to 3.0 r to the fetus. All of these determinations were made under excellent conditions and careless technique could easily result in dosages many times this large.

Limitation of Exposure

I would like to enumerate some of the things that we can and should do to limit exposure of the patient.

The fluoroscope is a valuable and helpful instrument that has some very real advantages such as the demonstration of movement, choice of positions, visualization of opaque materials and an immediate image.

Fluoroscopy has some inherent disadvantages, namely, poor detail and resolution, dim image, lack of a permanent record, time for dark adaptation and large radiation exposure.

Image amplification equipment has been helpful particularly in the examination of thinner parts of the body although its advantages are not as great in viewing thicker parts such as the abdomen and pelvis.[7] It seems likely that future designs will be even more helpful.

At the present time conventional fluoroscopes are in much wider use. Dr. Wendel G. Scott, in an address as incoming president of the American Roentgen Ray Society, stated

that one of the largest sources of unnecessary radiation to the reproductive organs is the routine fluoroscopy of infants and small children by some physicians and pediatricians.

It is generally agreed that fluoroscopy should not be used as a screening procedure. It is not as accurate as films, it does not furnish a permanent record, and it entails excessive exposure to the patient and to the fluoroscopist.

When a fluoroscope is used it should be of shielded design, properly adjusted, and its output should be tested and known. There should be at least 2 mm. of aluminum added filtration. The tube should be at least 18 inches from the patient. The output at the table top should not exceed 10 r/min. The eyes of the fluoroscopist should be completely accommodated, usually from 15 to 20 minutes. Relatively high kilovoltages and low milliamperages should be used (2 milliamperes should be adequate for most chest examinations and 3 milliamperes is sufficient for abdominal work.) The lead shutters should be adjusted so that the field size is as small as is practicable at all times. The fluoroscopic tube should be emergized only intermittently while actual observation is in progress and should be off while moving the patient or screen and while the examiner is engaged in contemplation. Some surveys have revealed machines which were operated at milliamperages up to 25 to compensate for inadequate dark adaptation. Under these conditions dosage to the patient and examiner can be truly excessive. The direct beam should be kept away from the gonads as much as possible. Films should be taken of doubtful findings.

In radiography it has been found that dramatic reductions in exposure are possible without sacrificing quality and using techniques which are available now. High kilovoltage, low milliamperage settings are indicated. Increased filtration and more careful use of diaphragms, cones, and local shielding are recommended. High speed screens, fast films, and complete development will also help reduce patient exposure. A recent technical demonstration showed a reduction from 6.9 r skin dose for a film of the pelvis to .2 r without any significant sacrifice in film quality.

It is imperative, particularly in young patients, to do the job correctly the first time and thus to avoid the necessity for retakes and repeat examinations.

Reconsideration of Indications

Thinking in terms of genetically significant exposure to radiation, it seems desirable to reconsider the indications for certain types of examinations.

Survey procedures should be evaluated, weighing the yield of significant case findings against the exposure of the population. The National Tuberculosis Association has placed well-deserved emphasis on its X-ray chest survey program; however, after careful evaluation they have concluded that there are few if any communities in the United States where routine chest X-rays are justified as the initial survey procedure in persons under 15 years of age. They recommend the tuberculin skin test as the initial procedure in this young age group with films being reserved for those with positive reactions. Chest survey procedures in the older age groups, particularly those past 40, continue to be one of the most economical and rewarding of any routine medical test. The yield in clinically significant case findings exceeds that of any other type of examination.

Well qualified physicians have recommended routine X-ray pelvimetry in all primiparous patients in the past, and are reluctant to give up this procedure; however, in view of the exposure to the mother and to the fetus it seems wise to use X-ray pelvimetry in the future only in those individual cases where there is a real clinical indication. Uterosalpingography, body section radiography in the pelvic region and other specialized procedures entailing appreciable gonadal exposure should be evaluated in light of these considerations.

Conclusions

In many of our patients the problem of exposure will be of little or no significance due to their age and the likelihood that they will not have children at any time in the future.

There certainly will continue to be sound and valid indications for X-ray examinations of all portions of the body in all age groups, but the physician should consider the problem of exposure. The doctor following the response of an ulcer patient to therapy or the orthopedic

specialist following the reduction and healing of a fracture or a congenital hip should allow time for nature to heal and for his treatment to have effect. We must try to be certain that preoccupation with possible theoretical effects on some future generation does not cause us to omit or postpone necessary examinations. Such concern may very possibly jeopardize the effectiveness of prolonged and costly treatment or could endanger the health or possibly the lives of our patients.

Thinking in terms of exposure, the physician should ask himself, "What do I seek to learn from this examination and does the useful information justify any likely hazard?"

When X-ray examination is requested, it is imperative that the radiologist, or any physician or dentist responsible for carrying it out, does not permit any concern over exposure to impair the quality and dependability of the procedure. Where exposure is a factor it is our responsibility to do the job while keeping the dose as low as possible, but to do it right, the first time.

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Please mail your scientific articles to The Journal of the Kentucky State Medical Association, 1169 Eastern Parkway, Louisville, Kentucky.

Osteomyelitis and Disc Space Infections of the Spine

K. Armand Fischer, M.D.

Louisville, Ky.

THE occurrence of infections of the spine has been greatly reduced in the last 15 to 20 years, and it is now not a very common condition. The scarcity of typhoid infections as well as Brucellosis infections has cut down the number of cases which are encountered. The incidence of osteomyelitis of the spine has dropped remarkably, along with bone infections in general, due to better control of primary infections of the skin, tonsils, gastrointestinal tract and other parts of the body with antibiotics.

Today even the picture of osteomyelitis of the spine and disc space infections has changed with modern medication. During the last year I have had an opportunity to study 5 cases of this condition. In the 10 preceding years none were encountered. During the years from 1926 to 1936 I saw many cases in children and adults which assumed varied forms. There were those which drained posteriorly around the spine, anteriorly in the flanks, and sometimes abscesses following the psoas muscle and pointing underneath the inguinal ligament. None of the recent cases formed abscesses which drained externally. Formerly the lamina, pedicles and other parts of the vertebra were seen to be involved often, even with abscesses around the spinal cord. This is a rare finding in recent years.

Mode of Infection

The mode of infection in osteomyelitis of the spine is hematogenous or traumatic through the introduction of a needle or open wounds. The hematogenous infection may come from anywhere in the body including the intestinal tract, kidneys, throat or lungs. Oftentimes the symptoms are mild, with a low grade fever, and mild leucocytosis, and rarely chills and high fever. Often the symptoms are prolonged several months before a proper diagnosis is made because now antibiotics are administered early in infections, and the inroads by the bacteria into the bone are slowed, and therefore the process seems less active and malignant. The bone changes may not appear for several months time. At times accidents are said to be precursors of the disease as when a man wrenches his back, or receives a blow on his spine. Frequently the patient has symptoms in his back which are "hard to account for." Early in the disease process a positive blood culture can be found in about 50% of the cases. In the cases which are being reported no positive blood cultures were obtained.

The offending organisms are frequently the staphylococcus, the typhoid bacillus and Brucella. Although any organism may cause the condition, the intestinal organisms frequently are involved.

The x-rays usually show a softening of an area on the anterior aspect of the vertebra, with an involvement of the adjacent disc space, and narrowing of the disc space. Frequently the adjacent vertebra becomes similarly involved, and at times there is a melting away of the adjacent bony surfaces. Usually healing is by collapse of the vertebral bodies with obliteration of the disc space and final bridging across the vertebra with new bone. Recurrence of symptoms is not the rule.

*Presented at the meeting of the Kentucky Orthopaedic Society during the KSMA Annual meeting on September 24, 1958.

**From the Section of Orthopaedic Surgery—University of Louisville School of Medicine, Louisville, Ky.

Treatment

The treatment for this condition is broad spectrum antibiotics when no organism can be recovered from the blood stream. Usually the patient will have extreme muscular spasm in his back, with marked loss of motion, making bed rest essential for relief of pain. For a number of weeks antispasmodics as well as pain relievers are necessary. Oftentimes the patient may have gastrointestinal symptoms which are disturbing. These are probably due to involvement of the sympathetic nerves anterior to the spinal column. Casts or braces are used after the severe pains are over, and the temperature has been normal for several weeks. Usually after several months time there is fair healing in the vertebra with some bridging so that immobilization of the spine is not needed. Antibiotics for a month or six weeks time usually suffices for the pus forming organism.

Case Reports

Case #1—J. C. a 65-year-old white executive, entered the Kentucky Baptist Hospital on 2-25-58 because of severe back pain, associated with a low grade temperature, and pains radiating into his hips.

On the 24th of December, 1957 the patient had a chill followed by lumbar pain and catches in his back. Following this he was admitted to the Kentucky Baptist Hospital where x-rays revealed osteoarthritis of his spine. He remained only 2 days for observation. The patient continued to have back pain until his readmission on 2-25-58.

Physical examination revealed a well developed and well nourished man, who had paroxysms of pain in his back on any movement. Examination revealed spastic spinal muscles, with 50% loss of straight leg raising, and some abdominal distention. His temperature was 99.4, and the sedimentation rate was 27. The white blood count was 13,300. neutrophils 65, and lymphocytes 28, hemoglobin 13.5 gms. and a hematocrit of 35.5. The urinalysis was negative.

X-rays of the spine revealed a destructive lesion in the adjacent bodies of L-3 and L-4, which was thought to be either a tuberculous arthritis or a hematogenous disc space infection and osteomyelitis.



Case No. 1 Osteomyelitis and disc space infection following an influenza and bronchitis attack.

After medical consultation he was treated with large doses of penicillin and streptomycin. The patient was kept at bed rest, and became afebrile in one week. He remained in the hospital for 31 days, after which he was made ambulatory and fitted with a Taylor type of back brace. On dismissal from the hospital the sedimentation rate was 24, and his temperature had been normal for 3 weeks. The patient was kept on penicillin and streptomycin for a total of 6 weeks.

Over a period of 6 months time the patient lost all his symptoms and obtained a complete range of motion in his spine. X-rays revealed a complete fusion between the third and fourth lumbar bodies at the end of 6 months.

Case #2—W. S., a 45-year-old desk worker, was first seen on 7-3-58 because of mid lumbar back pain and associated disability.

The patient gave a history of having been operated on February 5, 1958 for kidney stones which required drainage from the operative

wound. The operative wound healed after several weeks time, and the patient was free of pain for a period of 6 weeks. Following this he began to have back pain and was unable to continue his occupation because of the discomfort.

Examination of the patient revealed he had marked muscle spasm throughout the lumbar region, with almost complete loss of motion in his back. The bilateral straight leg raising test was complete. His ankle jerks were normal. His laboratory work was essentially normal except for a secondary anemia.



Case No. 2 Infection in the disc space and bone after a kidney removal and drainage from the wound.

X-rays revealed the patient had sclerosis and spurring on the second and third lumbar vertebrae, with apparent bridging and a suspected disc space infection between the second and third lumbar vertebrae.

The patient was treated by bed rest, heat and antibiotics and over a period of 2 months time lost his symptoms.

Case #3—Mrs. B. K., age 81, was admitted to the Kentucky Baptist Hospital on January 24, 1958 with severe pain in her lumbar spine, and an elevated white count, and a temperature range from 100 to 103 at 4 P.M.

The patient gave a history of having had diverticulitis beginning on November 19, 1957. This was followed by tarry stools. She was hospitalized on November 20th and an x-ray of her gastrointestinal tract revealed she had diverticulitis. She was treated with blood transfusions and other means, and was dismissed from the hospital on 12-15-57. She continued to get worse as far as her intestinal tract was concerned; and along with it she developed back pain.

Examination of the patient revealed she had marked abdominal tenderness and marked loss of back motion in all directions. She was completely disabled by her back pain and abdominal pain, and required opiates for relief.



Case No. 3 Bone involvement after an episode of intestinal hemorrhage due to diverticulitis.

X-rays revealed a destructive lesion of the second lumbar vertebra and narrowing of the disc space between L-1 and L-2.

The patient was treated with antibiotics, bed rest, sedation, and a special diet for her diverticulitis. Over a period of several months her symptoms subsided and by March 7, 1958 her temperature was entirely normal. Her hospital stay was quite stormy and required almost constant nursing care.

On 4-5-58 she was discharged from the hospital with a back brace and was walking. Over a period of another 6 months the patient had a complete recovery from the osteomyelitis of the spine with fusion of the L-1, L-2 bodies.

Case #4—J. B., age 41, was first seen on May 23, 1957 with a history of a low back sprain and intervertebral disc injury dating back to January 7, 1957.

The patient was found to have marked disability in his lumbar spine, with loss of motion, and evidence of sciatica on the left side.

The patient was treated conservatively with a low back brace until July 30, 1957 when he was admitted to Norton Memorial Infirmary, Louisville, Kentucky, where he was found to have evidence of a ruptured disc by myelogram. The patient had an intervertebral disc removal on August 7, 1957.

He was dismissed from the hospital on August 17, 1957, and returned to our office on August 29, 1957, where he was found to have spastic muscles throughout his lumbar spine. He was having intermittent paroxysms of muscle spasm which disabled him. The patient was again advised bed rest, heat and sedation, and he was readmitted to Norton Infirmary on September 8, 1957 where new x-rays were made, and he was found to have evidence of marked narrowing of the disc space between L-4 and L-5, and a ragged appearance to the adjacent bodies with evidences of a low grade infection in the intervertebral disc space.



Case 4 Disc space infection and osteitis following intervertebral disc removal.

The patient was treated by bed rest and heat. Because of continued extensive muscle spasm a spinal fusion was done on November 15, 1957. The patient recovered from his muscle spasm, and still had some evidence of sciatica on the left side.

Observe . . . . .

Diabetes Week

Nov. 15-23

Louisville General Hospital

Blastomycosis

THIS 63-year-old white man was admitted to the Louisville General Hospital on March 19, 1959 with a chief complaint of a sore on his face. He had been in good health until 3 months before admission when a small papule appeared on the bridge of his nose. The lesion gradually increased in size and a small amount of purulent exudate appeared in the center. The only other symptom was a small amount of pruritus. Approximately two weeks after the lesion appeared he consulted a physician who administered one injection of penicillin and prescribed a local ointment. The pruritus diminished considerably in intensity but the lesion continued to spread over his nose and both cheeks. There continued to be oozing of bloody and purulent material from the center of the lesion. He was then treated with "sulfa" tablets for approximately two weeks without any charge. Because of the continuing increase in size of the mass, a biopsy was taken which was said to have shown no evidence of malignancy. A smear made of the exudate subsequently showed numerous budding yeast forms, and he was referred to the Louisville General Hospital for treatment.

At the onset of his illness he had noticed a small amount of hemoptysis on one occasion but he denied dyspnea, chest pain, or cough except for this one instance. Occasional chilly sensation and frequent night sweats had occurred during the three month illness, but there had been no anorexia or weight loss. He specifically denied frequency, urgency, dysuria or hematuria.

The patient had worked as a miner for almost thirty years but for the last twenty years had been employed in lumbering in which his principle job was cutting trees.

On admission to the hospital, his temperature, pulse, respiration and blood pressure were all within normal limits. There was a 5 x 10 cm. irregular lesion on the bridge of his nose extending to both cheeks. The center of the lesion was crusted with purulent material and bled easily when touched. The border was raised and studded with small 1 mm. microabscesses and surrounding this border was a flat, erythematous aera of approximately 1 cm. in width. There was a 1 x 1 cm. left preauricular node and bilateral submandibular nodes which were firm and non-tender. Examination of the chest was within normal limits. The prostate was slightly enlarged, firm and non-tender. The rest of the physical examination was not remarkable.

Laboratory data on admission to the hospital showed a hgb. of 12.9 gm.%, WBC 6,200 with 60% polymorphonuclear leukocytes, Hct. 38%, VDRL non-reactive, urinalysis normal, and NPN 17 mg.%. Both histoplasmin and blastomycin skin tests were negative.

An admission chest x-ray revealed an area of increased density superior to the right minor interlobar fissure, bilateral apical fibrosis and emphysema.

The patient was afebrile during the first few days of his hospitalization. Several smears of the discharge showed rare, thick, double-contoured yeast cells without budding forms. One of four cultures was positive for Blastomycosis dermatides four weeks later. A biopsy of the edge of the lesion showed numerous giant cells and lymphocytes and on PAS stain a few organisms resembling blastomyces. A smear of the prostatic secretions was negative.

After the biopsy, the patient was given intravenous amphotericin B (Fungizone®) in doses ranging from 20 to 80 mg. daily in 1000 cc. of D_5/W over a six hour period of time. He



Figure 1

On admission to the hospital, the characteristic lesion of blastomycosis had spread over the nose to both cheeks



Figure 2

After two months therapy with amphotericin there is almost complete healing.

has received a total dose of 2900 mg. Therapy has been complicated by nausea, vomiting, chills, fever, local thrombophlebitis, albuminuria, and on occasions elevation of the NPN to as high as 61 mg.%. Despite this impressive list of complications, the chills and fever have been prevented by the administration of salicylates and antihistamines before each infusion, and the other side reactions have disappeared on lowering the dose of the drug given each day or by discontinuing therapy for 1 to 3 days.

After one week of therapy, there was beginning healing of the lesion manifested first by disappearance of the area of erythema, then by healing of the microabscesses and finally by scaling of the crusted central area.

Three weeks after therapy was started he again coughed up a small amount of blood streaked sputum. Chest x-ray showed almost complete resolution of the infiltrate in the right lung, but there was a new area of inifiltration in the left mid-lung field. Repeat x-rays 3 weeks later showed complete resolution of all infiltrates in either lung.

Discussion

Arthur C. White, M.D., Instructor in Medicine:

The patient's lesions are almost completely healed now but the facial lesion is shown in figure 1 as it appeared on admission and is typical of the cutaneous lesions of blastomycosis. Characteristically, the first manifestation is a small papule which breaks down and drains small amounts of purulent material. The lesion then spreads peripherally with central clearing of the previously involved area, a zone of erythema at the advancing margins, and inside the area of erythema a raised border with numerous small abscesses in which the organism can usually be readily found. After therapy the erythema and microabscesses have disappeared so now there is only a small amount of dried material on the left cheek (Figure 2). The infiltrates which have been present in both lungs have also completely resolved during therapy.

This is a relatively uncommon disease but is most frequently encountered in the Southeastern United States. The reservoir of blastomyces dermatides is unknown nor is it known how the infection is acquired by man. The disease occurs in two clinical patterns. The first is cutaneous in which there is no involvement of any other organs and the cutaneous lesion in this form of the disease appears on the exposed areas of the arms and on the face. The disease is believed to be acquired by direct inoculation of the fungus into the skin.

In the disseminated or systemic form, multiple organs are involved and in order of frequency the lungs, subcutaneous tissue, bones and joints, genitourinary tract, gastrointestinal tract and the meninges may be infected with lesions which resemble tuberculosis both clinically and pathologically. In the disseminated or systemic form, multiple organs are involved and in order of frequency the lungs, subcutaneous tissue, bones and joints, genitourinary tract, gastrointestinal tract and the meninges may be infected with lesions which resemble tuberculosis both clinically and pathologically. In the disseminated form, the fungus is believed to be acquired through the lungs and then

spread to the skin and other organs through the blood stream.

An absolute diagnosis can be established only by culture but smears from exudates and sputum or biopsies may show the thick double-contoured yeast which have only single buds and are 8 to 15 microns in diameter. In addition, considerable help may be obtained by skin tests and complement-fixing antibodies.

The skin test in blastomycosis has the same significance as a positive tuberculin or a positive histoplasmin skin test; that is, it indicates either present or past infection with blastomyces. The complement-fixing antibodies are more specific and when elevated are indicative of recent infection. Since there is a cross reaction between the antigens, histoplasmin and blastomycin, it is important that serological and skin tests be done with both antigens at the same time. If there is a positive test with both antigens, the reaction with the homologous antigen will usually be stronger; thus, in a patient with histoplasmosis, the complement-fixing antibodies may be positive both for histoplasmin and blastomycin but the titer for histoplasmin will usually be higher.

In addition to their diagnostic aid, complement-fixing antibodies and skin tests have a prognostic significance. The best prognosis can be expected in patients with a postive skin test and negative serological tests. The converse is also true in that negative blastomycin skin tests and positive complement-fixing antibodies indicate a poor prognosis.

At the present time there are two effective means of treating systemic blastomycosis. The older of the two is the administration of stilbamidine or 2 hydroxystilbamidine. The toxicities encountered have included nausea, vomiting, trigeminal neuralgia, leukopenia, and occasional severe hepatic or renal impairment.

Amphotericin B is a more recent drug and has been reported to be effective in systemic blastomycosis, histoplasmosis, cryptococcosis (torula), candida infections, sporotrichosis, and coccodiomycosis and is the first effective antimicrobial therapy for the systemic forms of all of these fungus infections. It is absorbed poorly after oral or intramuscular administration and must be given slowly intravenously. Effective blood levels can be maintained for over twenty-four hours by a single 6 hour infusion. Although there is poor penetration into the normal spinal fluid, effective spinal fluid levels are found after intravenous therapy in patients with torula meningitis in whom the spinal fluid protein is elevated.

The toxicities reported with amphotericin have almost all been encountered in the patient presented today: nausea, vomiting, chills, fever, local phlebitis, albuminuria and nitrogen retention. In addition, abdominal pain, melena and headache have been frequently a sequela in other patients. All of these side effects have been reversible on decreasing the daily dose of the drug or temporarily discountinuing therapy.

The relative merits of these two compounds are not yet known; however, some patients who have become resistant to stilbamidine therapy have responded to amphotericin. In the systemic form of blastomycosis there have been relapses of the disease with all forms of therapy presently available.

Hear . . . . .

Two Outstanding Panels

at

the 1959 Annual Meeting

Sept. 22-24

SPECIAL ARTICLES

KSMA Testimony Before House Ways and Means Committee on Forand Bill (HR4700), July 17, 1959

CARL FORTUNE, M.D.
Lexington, Ky.

MR. Chairman—my name is Carl Fortune. I am a practicing physician in Lexington, Kentucky, where I practice internal medicine. I am here to day to present the views of the Kentucky State Medical Association on HR 4700 urging that this Bill not be reported favorably by the Committee.

Some ten years ago the Kentucky State Medical Association, made up of more than 2,000 members, began to realize the necessity for the physician to do more than to treat the physical and mental ills of his patient. Now more and more physicians in our state have accepted the responsibility of helping the patient to solve his socio-economic problems pertaining to medical care.

In 1949, the Medical Association sponsored and financed the Blue Shield Medical Care Plan in the state that has had a phenomenal growth and has and is making it possible for 585,000 people to budget their medical care bills. The Association has encouraged and worked with commercial insurance companies to develop similar plans.

The Association and Blue Shield are now working in the state on the development of a special plan to provide medical care for the aged on a reduced fee basis that the patient with limited income and resources can afford. In fact, Mr. Chairman, the medical profession in Kentucky for many years actually has been taking care of the aged, accepting a reduced fee or no fee at all, depending upon the patient's circumstances.

The Association has supported a liberalization of the Workman's Compensation Act and various public health measures which accrue to the public's improved health care.

Recently, after careful study, the Kentucky State Medical Association has set into motion a new policy expanding the health care of the aged in our state. Included in this program are requests for new construction and enlarging of present facilities for nursing homes; experimentation in the adding of a functional wing to existing hospitals for convalescent care; utilizing existing facilities such as heat, laundry, food, etc., thus cutting down on the over-all costs.

This policy also calls for a visiting nursing service to provide for the chronically ill in the home, operating under the supervision of the family physician, closer cooperation with the nursing homes, and encouraging a program of education on making greater use of the skills of our senior citizens.

Apartments for the aged are being developed in urban areas of Kentucky. One such project will have nearly 200 units located in the downtown area where aged couples can live and in the event of illness they will be near to doctors and medical facilities.

Members of this Association are actively cooperating with the Governor's Commission for the Aged in Kentucky. Eight physicians are on this commission which plans to employ an Executive Director and is embarking on an extensive survey and action program in the State.

Kentucky physicians, working as a part of the health service team, had their part in contributing to the situation which now finds the average life expectancy at the age of 70 instead of age 50 as it was at the turn of the century. In view of this development, we will do all we can to find the answers to this problem we helped create.

Tremendous strides have been made by the medical profession, hospital groups, and the

(Continued on page 1122)

wherever there is inflammation, swelling, pain

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Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery. By activating fibrinolytic factors VARIDASE shortens the *undesirable phase*, limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

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Supplied: boxes of 24 and 100 tablets.

1. Innerfield, I.: Clinical report cited with permission
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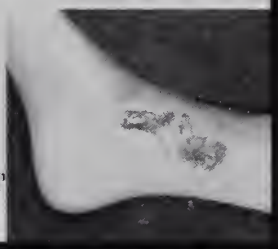
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FORCE INJURY
severe bruises
. . . swelling
. . . cleared
by fifth day[2]





VARICOSE ULCER
15 years duration
. . . resolved with
VARIDASE[1]





INFLAMMATORY DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]





INFECTED LACERATION
marked reversal
in 3 days . . .
returned
to school . . .
closure advanced[1]





THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]





REFRACTORY CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

Protocol—Clinicopathologic Conference

KSMA ANNUAL MEETING

Columbia Auditorium **10:30 a.m., Wednesday, September 23**

A 29-year-old white housewife, office worker and mother of five-year-old twins was admitted to the hospital in July 1952, for vaginal hysterectomy for second degree prolapse of the uterus. She had had pre-eclampsia and some postnatal complications, but except for increasing pelvic pain, had been well since delivery. At this admission her blood pressure was 130/80, temperature, pulse and respirations normal, and the chest normal to percussion and auscultation. No X-ray examination was done. Examination of the blood showed hemoglobin 11.0 gms., RBC 3,550,000, WBC 5,150, polymorphonuclear leukocytes 52%, non-segmented 1%, lymphocytes 38%, monocytes 6%, and eosinophiles 4%. Postoperative course was uneventful and she was discharged on the 10th hospital day.

She was not seen again until January, 1954, at the age of 31, when she consulted her family doctor complaining of cough for two months with pain in the chest and aching all over. At this time she had a temperature of 103°F, the throat was red, and rales were heard in the left chest anteriorly and posteriorly. The impression was bronchitis and she was treated with 600,000 units of Penicillin and Empirin #3. On the following day the temperature was normal and Penicillin was again administered. A few days later she appeared improved but still had considerable cough, and fluoroscopic examination revealed an increase in the bronchovascular markings on both sides. Approximately three weeks later she returned with a temperature of 100°F, and the impression was tonsillitis and bronchitis. Penicillin was again administered with subsequent improvement and clearing of the lungs to auscultation. No X-ray studies were done.

Approximately two years later, in March 1956, she was again seen with chills, fever, cough, generalized muscular aching and sore throat. Temperature was 101°F, the pharynx was diffusely congested, and rales were heard, especially in the right base posteriorly. Fluoroscopic examination revealed increased bronchovascular markings in the right lung and questionable hazy consolidation of the right lower lobe. X-ray films made at this time (See Fig. 1) showed hazy consolidation in the right lung field and some increased markings in the left lung field with hazy infiltration interpreted as bilateral pneumonia, possibly yeast infection or histoplasmosis. She was given



Figure 1

Penicillin and Achromycin® and returned in two days improved, with temperature of 99°F, but little if any clearing of the lungs to fluoroscopy. Four days later the temperature was normal but she continued to cough, and fluoroscopic examination showed the hazy consolidation had improved. She was continued on Achromycin and became asymptomatic and afebrile with lungs clear to percussion and auscultation. The X-ray films taken on April 17 (See Fig. 2) revealed



Figure 2

*The Committee on Scientific Assembly and Arrangements urges that this material be read before the meeting. The CPC will be moderated by John D. Allen, Jr., M.D., Louisville, and discussant will be Carlos A. Fish, M.D., Louisville. Pathologist will be Robert J. Ritterhoff, M.D., Covington; and radiologist, R. H. Marshak, M.D., New York, N. Y.

mottled infiltration bilaterally with no definite consolidation and the impression was virus pneumonia.

She was told to return in about three weeks for repeat chest X-ray but was not seen again until November 29, 1956, complaining of cough and mild upper respiratory infection. She weighed 180 pounds. The temperature was normal, blood pressure 120/80, and the blood count was normal. Sedimentation rate was 17 mm. in one hour. She was given saturated solution of potassium iodide, five drops three times a day. The chest X-ray showed the hazy infiltration persisting, but to a lesser degree. (See Fig. 3). A radiologist was

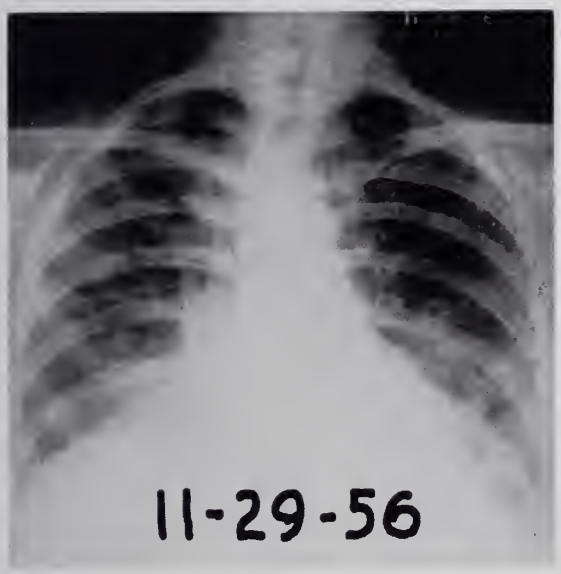


Figure 3

consulted who suggested several unnamed possibilities and suggested that bronchoscopy might be indicated. However, the patient declined further treatment and was not seen again until July 1957, when she complained of pain in the right upper and lower quadrants of the abdomen for the past 24 hours, which was severe enough to prevent sleep, but not related to meals, bending, twisting or anything else. There was no nausea, vomiting, chills, frequency of urination or diarrhea. The lungs were clear to percussion and auscultation. The blood count at this time showed 15.95 gms. of hemoglobin, and a white blood count of 9,100 with a normal differential. The impression was possible cholecystitis or possible early appendicitis. She was given Penicillin and Probanthine, and advised to return if she did not improve.

She was then not seen again until January 20, 1959, when she stated she had been sick three or four days with a productive cough, some chills, feverish sensation and pinkish sputum. She weighed 197 pounds. Temperature was 98.6°F, blood pressure 140/80, nose and throat were negative but scattered rales were heard throughout all lung fields with some ronchi present. X-ray films of the chest showed irregular areas of infiltration throughout the lower two-thirds



Figure 4

of both lung fields. (See Fig. 4). The impression was probably atypical pneumonia, although the possibility of other lung diseases was not excluded. She was given Penicillin and Achromycin, and two days later reported improvement with no further hemoptysis, chills, fever, or chest pain. The X-ray films were again seen by a consulting radiologist who thought that there was some basic underlying lung pathology with a superimposed infection. She had been asymptomatic in the intervals during which she had not been seen. The X-ray interpretation suggested that metastatic malignancy should be considered. Treatment with Achromycin and potassium iodide were continued.

She was admitted to the hospital on February 11, 1959, when she stated that she was having exertional dyspnea with cough and mucoid sputum. The blood pressure at this time was 150/100, pulse 96, respirations 22, temperature 98.6°F. Physical examination was negative except for scattered rales, particularly over the lung bases. The blood count at this time showed 5,900,000 red cells, hemoglobin 17.3 gms., hematocrit 52%, WBC 12,800 with 72% neutrophiles, 1% eosinophiles, 26% lymphocytes and 1% monocytes. Urinalysis was normal. Smears and cultures of the sputum for acid-fast bacilli were negative and the histoplasmin skin test was negative. A sedimentation rate was 13 mm. in one hour. Serum calcium 9.8m-Eq/L; NPN 33 mgm.%. The serum albumin 4.2; globulin 2.0 and total protein 6.2 gms. VDRL negative. Culture of the sputum showed streptococcus pyogenes sensitive to all antibiotics. A right scalene fat pad was removed for biopsy and revealed only normal lymph nodes.

She was re-admitted on February 21st, and a right thoracotomy with removal of specimens from all three lobes of the right lung for biopsy was performed.

EDITORIALS

Disruption of Abdominal Wounds

IN spite of the increased knowledge of surgical bacteriology, surgical technic, antibiotics, nutritional and electrolyte balance, anesthesiology and intestinal intubation, the disruption of an abdominal wound is still a dreaded serious complication of abdominal surgery. Often it occurs in those who can least withstand a complication—the aged, the malnourished, the obese, the emphysematous, the bronchitic, and those with hepatic, cardiac, renal and metabolic disease. It is also likely to occur following emergency operations where insufficient time has been available to get the patient in optimum condition to undergo operation, many of which are necessarily long such as emergency gastrectomy for bleeding.

When time permits much can be done during the pre-operative period to prevent disruption. During the operation adherence to the classical but still essential principles of good surgical technic is an important factor in prevention. Gentleness, complete hemostasis, accurate approximation without tension, strict asepsis, require time and patience but supply large dividends in prevention of morbidity and mortality. During the post-operative period much can be done to prevent disruption by diligent constant attention to allay cough, splint the wound, decrease distension, supply good respiratory exchange of pure air, and furnish adequate proteins, vitamins, electrolytes, calories and water. In doing so one must ever be aware of the danger of overtreatment.

During the operation the surgeon also has an opportunity to attempt to prevent disruption. Many methods of closing the abdominal wound have been devised and practiced but, so far as we know, none of them is an absolute guarantee against disruption. We have tried many of them and have made a prolonged and serious effort to evaluate most of the others. We believe the only methods that offer good security against disruption are those that consist of some type of non-absorbable suture through all of the layers of the abdominal wall except when the Smead stitch is used the suture does not include the skin. The Smead stitch is a vertical far and near stitch through all of the layers except the skin. One method that we have used many times is the Joseph Price in which all layers are sutured with interrupted sutures of some non-absorbable material without effort to approximate the individual layers. Dr. Price and his successor Dr. Kennedy used silkworm gut. This gave good security against disruption but for us resulted in unsightly scars and a high incidence of hernia.

The method we prefer is as follows: Interrupted sutures of #2 cotton spaced 1½ to 2½ centimeters are inserted through all of the layers including the skin but are not tied. To hold them against the peritoneum to avoid the intrusion of intestine, heavy snaps are put on the ends and allowed to dangle. After placing these sutures the individual layers are sutured separately, the peritoneum and posterior sheath with continuous #0 chromic catgut and the aponeurosis with interrupted 00 cotton. The #2 cotton thru and thru sutures are then tied over guards of small rubber tubing. Any remaining defects in the skin are closed with interrupted 0000 cotton. The #2 cotton sutures remain until the wound is firmly healed. It is essential for the thru and thru sutures to be tied loosely.

We learned of this method many years ago and have been unable to find the name of the surgeon who first described it and the reference. It is most likely that more than one devised and practiced it. We have seen it used by other surgeons some of whom use heavy silk or steel wire. We prefer cotton to silk since it causes much less reaction in the wound and prefer cotton to wire as it is much easier to handle.

Malcom Thompson, M.D.
Blaine Lewis, M.D.

ORGANIZATION SECTION

22 Speakers Highlight Program of 1959 Annual Meeting

A program featuring 22 medical authorities presenting topics which should be of vital interest to every physician is bound to make the 1959 KSMA Annual Meeting an outstanding addition to the postgraduate program offered Kentucky physicians," said R. W. Robertson, M.D., Paducah, chairman of the Committee on Scientific Assembly and Arrangements.

Doctor Robertson commented on the variety and depth to be found in this year's program and urged that all physicians review the program which appeared in the August 1959 issue of the Journal.

This year's policy of splitting the specialty group meetings into two sessions so that six groups will meet on Tuesday, afternoon, September 22, and six groups will gather on Thursday morning, September 24, should offer a special advantage to physicians who will have an opportunity to attend other specialty group sessions, while still taking advantage of their own.

Other outstanding offerings of this year's meeting will be a Clinicopathologic Conference on Wednesday, September 23, at 10:30 a.m., and two panel discussions. A panel on "Biliary Tract Disease" will be presented on the opening day of the meeting, Tuesday, September 22, at 10:30 a.m. The meeting will close with a panel on "Reversible Renal Failure" on Thursday, September 24, at 3:30 p.m.

The usual high calibre scientific and technical exhibits will also be on display. Doctor Robertson and his committee urge all members to take advantage of the opportunity for increased knowledge they afford. There will be 11 scientific displays and 65 technical exhibits.

An innovation this year will be a luncheon honoring new KSMA members which is scheduled for Tuesday noon, September 22. All members who joined the Association after September 1, 1958 have been invited to attend.

The President's Luncheon, always a highlight of the meeting, will have as its featured speaker Assistant Secretary of Defense (Health and Medical) Frank B. Berry, M.D., Washington, D. C.

Other traditional adjuncts to the meeting will include: the U of L Alumni Reunion Dinner at the Crystal Ballroom of the Brown Hotel on Thursday night, September 24, and the Kentucky State Medical Golf Association tournament at Big Spring Country Club on September 22, 23, and 24.

The Committee on Scientific Assembly and Arrangements urges that all members take advantage of the many opportunities for PG education and fellowship offered at the 1959 Annual Meeting.

1959 Diabetes Detection Drive Set for November 15-23

Eighty Kentucky counties have already named chairmen for the 1959 Diabetes Detection Drive which will be conducted by the KSMA from November 15-23 in cooperation with the American Diabetes Association, according to Robert J. Hoffmann, M.D., South Fort Mitchell, chairman of the Associate Committee on Diabetes.

Returns from counties are still continuing to come in, Doctor Hoffmann said, and the committee is hoping for full participation during Diabetes Week. Last year 180 newly proved diabetics were discovered and 90,598 free tests were made in Kentucky.

"This year it is hoped that we can have even greater physician cooperation," Dr. Hoffmann said, "and increase our chances of discovering a greater number of diabetics."

Working with Doctor Hoffmann for the success of this year's drive are the following members of the Associate Committee on Diabetes: Herald K. Bailey, M.D., Ashland; George P. Carter, M.D., Louisa; Marcus A. Coyle, M.D., Springfield; Thomas J. Crume, M.D., Owensboro; Albert H. Joslin, M.D., Beaver Dam; Franklin B. Moosnick, M.D., Lexington; Stanley T. Simmons, M.D., Louisville; Arthur T. Hurst, M.D., Louisville; Esten S. Kimbel, M.D., Frankfort.

An article by Doctor Hoffmann on the Diabetes Drive is scheduled to appear in the October issue of the Journal.

Seminar on Alcoholism Planned

The Kentucky Commission on Alcoholism is planning a seminar which will be held at the Brown Hotel in Louisville on November 5. Several out-of-state speakers who are highly qualified in the treatmcnt of alcoholism, as well as some Kentucky physicians who are outstanding in this field are to be on the program. Full details on the seminar will be included in the October issue of the Journal.



The McDowell Apothecary Restoration Committee shown above is the group that actually did the work in restoring the McDowell Apothecary Shop. Pictured—(l to r)—are E. Murphy Josey, Frankfort, secretary of the Kentucky Pharmaceutical Association; Francis Massie, M.D., Lexington, co-chairman of the KSMA McDowell Home Committee; George Grider, Danville pharmacist; Dean Earl P. Sloan, University of Kentucky College of Pharmacy; Sterling Coke, Lexington businessman; and William P. Curry, Lexington pharmacist.

Announcement of McDowell Stamp Made at Apothecary Dedication

A highlight of the dedication of the Apothecary adjoining the McDowell Home Shrine in Danville on August 14 was the announcement that Postmaster General Summerfield had authorized the issuance of a stamp in December, 1959, honoring Ephraim McDowell, the father of abdominal surgery.

The announcement of the stamp was made by Robert W. Robertson, M.D., Paducah, KSMA president, who said that news that the stamp would be issued during the 150th anniversary year of Doctor McDowell's now famous operation on Jane Todd Crawford came in a phone call from Kentucky's Senators John Sherman Cooper and Thruston B. Morton. He said 120 million stamps would be printed in maroon and white, featuring a likeness of Doctor McDowell.

Following the dedication, the keys to the restored McDowell Apothecary were turned over to the KSMA by President Crawford Meyer of the Kentucky Pharmaceutical Association. In accepting the keys Doctor Robertson said, "We shall always be grateful for the splendid efforts of you men in pharmacy who have made this lasting contribution to this shrine and to the history of both pharmacy and medicine in Kentucky."

One of the principal speakers at the dedication was John C. Burch, M.D., professor of gynecology at Vanderbilt University, who said, "In studying Doctor McDowell, surgeons find their ideal. He endowed surgery with a great tradition."

Dr. Glenn Sonnedecker, associate professor of the University of Wisconsin School of Pharmacy, outlined the history of pharmacy and its former role as a part of medical practice. He called the McDowell era the beginning of research that led to pharmacy as a separate—but still related science in its own right.

The apothecary—first west of the Alleghenies—was built about 1792. It was rebuilt and refurnished by the Pharmaceutical Association and drug manufacturers in cooperation with the Kentucky State Medical Association.

Pictures of the dedication at which E. M. Josey, secretary of the KPA, presided appear on this page and on page 1082 of this issue.

Journal's Second Symposium Issue Scheduled for November

The second annual Symposium Issue of the Journal of the KSMA is scheduled for November and will be on "Carcinoma of the Lung," according to an announcement from Sam A. Overstreet, M.D., Louisville, Journal editor.

In announcing the Symposium Issue, Doctor Overstreet said, "We are indeed fortunate to again have the services of Wallace Herrell, M.D., Lexington, as special symposium editor," Doctor Herrell also directed last year's symposium on "Diabetes" which appeared in the October, 1958 Journal.

Doctor Herrell announced the following titles and authors for this year's symposium.

"Etiology, Symptomatology and Diagnosis of Carcinoma of the Lung"
Oscar O. Miller, M.D., Louisville

"Roentgenographic Evaluation of Primary Carcinoma of the Lung"
Kenneth D. McGinnis, M.D., Lexington

"The Cytologic Examination of Sputum and Bronchial Secretions"
William M. Christophersen, M.D., Louisville

"The Role of Endoscopy in the Diagnosis of Carcinoma of the Lung"
Marc J. Reardon, M.D., John R. Woodyard, M.D., and Edgar Wippermann, M.D., Covington

"Surgical Management of Malignancy of the Lung"
James B. Holloway, M.D., Lexington

"The Use of Chemotherapeutic Agents and Roentgen Ray Therapy in Carcinoma of the Lung"
Jesshill Love, M.D., and Wesley G. Farnsley, M.D., Louisville

Blue Cross-Blue Shield Announce Changes For Non-Group Membership Requirements

Blue Cross-Blue Shield have announced two changes in eligibility requirements for people who do not join through a group at their places of employment.

After September 30, persons working where there are 10 or more employees will not be eligible for non-group membership. They will be accepted on a group basis only.

Also, non-group applications will not be accepted from persons who have reached the age of 65, after September 30. Until October 1, anyone 65 years or under, and in good health, may apply regardless of place of employment.

D. Lane Tynes, executive director of the Blue Cross-Blue Shield Plans says that these changes are necessary because many organizations offering hospital-surgical protection cancel members who reach age 65 or retire; others cancel when a chronic or incurable condition develops; some reduce benefits at 60 or 65 years of age.

"It is not fair to enrolled Blue Cross-Blue Shield members, or actuarially sound for Blue Cross-Blue Shield to extend protection to these people who have been enrolled with some companies who cancel them at the age they need protection the most," Mr. Tynes said. He feels that all hospital-surgical plans should extend coverage to their members regardless of age or physical condition as long as the members wish to carry the protection. Too many insurance companies want to protect only those in good health.

Mr. Tynes said that any firm employing five or more people is eligible to apply for a group plan; that only those people self-employed, unemployed, or working where there are less than 10 employees would be eligible to apply for non-group protection. and that the policy of Blue Cross-Blue Shield to continue protection on members regardless of age or physical condition should be adopted by the insurance industry, also.

TB Symposium in Madisonville Set for October 14

The annual postgraduate symposium at District One State TB Hospital in Madisonville is scheduled for Wednesday, October 14, according to A. B. Dickey, M.D., Hospital director.

The symposium will be sponsored jointly by KSMA Councilor Districts 1, 2, and 3, the Kentucky Chapter, American Academy of General Practice, and the Kentucky State Tuberculosis Commission.

Featured speakers will be Joseph Little, M.D., and Dr. Emil Kotcher, both of Louisville. Doctor Little, of Children's Hospital in Louisville, will speak on "Pulmonary Histoplasmosis, a Common Cause of Unexplained Fever in Children." Doctor Kotcher, director of Scientific Laboratories at the State Department of Health will have as his subject, "Laboratory Diagnosis of Virus Infection."

Councilors J. Vernon Pace, M.D., Paducah (1st), Walter L. O'Nan, M.D., Henderson (2nd), and Ralph D. Lynn, M.D., Elkton (3rd), urged physicians in their districts to take advantage of this postgraduate educational opportunity.

Athletic Injury Conf. Attracts Crowd of 125

The first Athletic Injury Prevention Conference sponsored by the KSMA was enthusiastically received by 125 coaches and others interested in athletics who attended the one-day meet in Lexington on August 12.

Held in conjunction with the Annual Coaches Clinic at the University of Kentucky, the Conference was sponsored by the KSMA in cooperation with the Kentucky High School Athletic Association, Kentucky Advisory School Health Council, and the University of Kentucky Athletic Association.

Many of the coaches expressed the hope that it would be held annually in conjunction with the Coaches Conference. Planned by the KSMA Committee on School Health, headed by Carroll L. Witten, M.D., Louisville, the Conference was the first of its kind ever held in Kentucky.

Featured on the program were leading names in the Kentucky sporting scene and several Kentucky physicians. Panel discussions dealing with the prevention and recognition of injuries and the responsibilities of coaches, trainers, athletes, and physicians regarding athletic injuries were followed by lively discussion by both participants and members of the audience.

Pictures of the participants in the Conference appear elsewhere in this issue.

Sky Beds for Invalids Now Available

Announcement of a new service which will offer Sky Beds for invalid patients who must travel was made recently by one of the nation's major airlines. The report said that most of airline's 4-engine planes will accommodate the installation of the Sky Bed, with the cost to the patient varying proportionately with the type of aircraft and the number of seats required to be blocked off. Sky Bed passengers must be accompanied by an attendant specified by the passenger. Complete details are available to physicians by calling the Reservations Department of Eastern Airlines at JUniper 4-4131 in Louisville.


DR. EPHRAIM McDOWELL
1771-1830
EMINENT AMERICAN PHYSICIAN AND SURGEON. THE FATHER OF AMERICAN SURGERY. LIVED AND PERFORMED THE FIRST LAPAROTOMY OPERATION IN THIS HOUSE IN 1809.

Top Row—left—President Crawford Meyer of the Kentucky Pharmaceutical Association and President R. W. Robertson, M.D., of the KSMA, pose by the historical marker at the McDowell Home site.

Top Row—right—The McDowell Home and Apothecary as they appeared before the dedication ceremonies. The Apothecary was restored by the Kentucky Pharmaceutical Association and turned over to the KSMA following the dedication.

Third Row—left—With more than ordinary interest in the dedication were Mrs. Philip Blackerby, Louisville, member of the Woman's Auxiliary McDowell Home Committee; Doctor and Mrs. Charles Vance, Lexington (Dr. Vance is co-chairman of the McDowell Committee); and Mr. and Mrs. Crawford Meyer, Louisville.

Third Row—center—KSMA President R. W. Robertson, expressed the Association's appreciation for the generous contributions made by the Pharmaceutical Association. Crawford Meyer is in the background.

Third Row—right—Mrs. Estelle Crawford, Danville, (right) hostess, discusses the McDowell dedication with one of the participants who helped to make the dedication a success.

Second Row—left—A bit more than pleased with the dedication were members of the Auxiliary's McDowell Committee: Mrs. W. O. Bullock, Lexington; Mrs. Elmer Henderson, Louisville; Mrs. Walker Owens, Mt. Vernon; and Mrs. Philip Blackerby, Louisville.

Second Row—right—E. Murphy Josey, secretary of the Pharmaceutical Association, presided at dedication ceremonies of the Apothecary Shop, which were attended by an estimated crowd of more than 200.

Bottom Row—left—Doctor Robertson and Mr. Meyer pose with equipment donated by an interested pharaceutical house.

Bottom Row—right—Providing atmosphere for the dedication were these lovely hostesses shown behind the McDowell Home.

Program of Lexington Clinic Conf. on October 21-22 Announced

Announcement of the Fourth Annual Fall Clinical Conference of the Lexington Clinic which will be held on Wednesday and Thursday, October 21 and 22 at the new clinic building on South Broadway, Lexington, was received as the Journal went to press.

The Wednesday session will start at 10 a.m. and adjourn at 5:00 p.m. First on the program will be a discussion of "Problems in the Diagnosis of Pulmonary Disorders" which will be moderated by W. P. Wharton, M.D. Participants include: Doctor Wharton, "Evaluation of Dyspnea;" K. D. McGinnis, M.D., "Laminography of Non-tuberculosis Intrathoracic Disease;" Albert Balows, Ph. D., "The Laboratory Diagnosis of Infectious Disease of the Lung;" and J. B. Holloway, M.D., "Surgical Diagnostic Techniques."

Second session of the morning will be moderated by Eugene Todd, Jr., M.D. Participating will be: F. M. Massie, M.D., "The Value of Biopsy in All Breast Tumors," J. D. Ruff, M.D., "Pitfalls in the Diagnosis and Treatment of Anemia," T. R. Miller, M.D., "The Painful Shoulder;" A. B. Combs, M.D., "Surgical Treatment of Deafness."

Following the luncheon Wallace E. Herrell, M.D., will moderate a "Symposium on Rheumatology." Part I on Diagnosis will include: J. D. Ruff, M.D., "Rheumatoid Arthritis;" A. L. Cornish, M.D., "Gouty Arthritis;" W. E. Herrell, M.D., "Osteoarthritis and Symptomatic Arthralgias;" and R. C. Quillin, M.D., "Roentgenographic Diagnosis."

Members of a panel on treatment will be: R. C. Quillin, M.D.; Donald Lange; M. G. Brown, M.D.; A. L. Cornish, M.D.; and J. D. Ruff, M.D.

The Wednesday program will close with a panel on "Special Problems in the Management of Diabetes." Taking part will be: N. T. Macfarlane, M. D., "The Diabetic Child;" D. M. Johnston, M.D., "Obesity and Fat Metabolism in Diabetes;" and J. B. Selby, M.D., "Oral Agents and the Newer Insulins."

Eugene Todd, Jr., M.D., will moderate the first session on Thursday, October 22. It will include: E. W. Christensen, "Some Aspects of the Management of Maxillofacial Trauma;" W. L. Cooper, M.D., "Office Proctology;" J. A. Harris, M.D., "Transurethral Prostatic Surgery;" P. H. Jones, M.D., "Movement Disorders."

Closing the program will be a "Symposium on Coronary Sclerosis" moderated by A. L. Cornish, M.D. Participants will be: J. T. McClellan, M.D., "Pathology;" C. H. Fortune, M.D., "Diagnosis of Coronary Disease;" R. M. French, M.D., "Treatment of Myocardial Infarcts;" A. L. Cornish, M.D., "Treatment of Angina;" and J. B. Holloway, M.D., "Surgical Considerations."

M.D.'s from 17 Countries Invited to London TB Seminar

Physicians from a 17 county area are invited to attend the postgraduate seminar at the District Five State TB Hospital in London on October 29 by Thomas H. Biggs, M.D., medical director and superintendent.

The KSMA and the KAGP are both cooperating with the hospital in presenting the seminar. Counties in the District include: Bell, Breathitt, Clay, Harlan, Jackson, Knott, Knox, Laurel, Lee, Leslie, Letcher, McCreary, Owsley, Perry, Pulaski, Rockcastle, and Whitley.

Following is the complete program as released by Doctor Biggs.

3:00 p.m. "Management of Resistant Heart Failure"
L. T. Minish, M.D., Louisville

3:30 p.m. "New Developments in Management of Leukemia"
Ellis Fuller, M.D., Louisville

4:00 p.m. "Recent Developments in Thoracic Surgery"
John Harter, M.D., Louisville

4:30 p.m. "Differential Diagnosis of Abdominal Pain"
Hoyt Gardner, M.D., Louisville

7:00 p.m. "Heart Disease of Pulmonary Origin"
Ralph Denham, M.D., Louisville



Members of the Executive Committee of the Rural Kentucky Medical Scholarship Fund are—l to r—Cass Walden, Edmonton; J. Murray Kinsman, M.D., Louisville; Gaithel Simpson, M.D., Greenville; C. C. Howard, M.D., Glasgow, chairman; William R. Willard, M.D., Lexington; Russell Teague, M.D., Louisville; and Tarleton Collier, M.D., Louisville.

Locations Rezoned by RKMSF Exec. Committee

A rezoning of locations in which a scholarship recipient will now be approved for practice was one of the projects undertaken at a meeting of the executive committee of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund on July 28, according to C. C. Howard, M.D., Glasgow.

Before the rezoning, the term "rural area" was generally defined as an area in Kentucky which is not within twenty miles of a city having a population of 50,000 or more, nor within 10 miles of a city having a population between 5,000 and 50,000.

Now certain areas have been excluded and a recipient will *not* be approved to practice in the following locations and meet his obligation to the scholarship program:

Louisville and Jefferson County
Covington and Kenton County
Lexington and Fayette County
Owensboro and Daviess County
Paducah and McCracken County
Newport and Campbell County
Also the cities of Ashland, Bowling Green, Henderson, Middlesboro, Hopkinsville, Frankfort, Madisonville, and Richmond.

A recipient may practice anywhere in Kentucky except the above listed counties and cities.

Doctor Howard pointed out that the rezoning was brought about because of the shifting of population from rural counties to urban centers, lack of sufficient locations with less than 5,000 or more for recipients who will start practicing in the future, and the fact that the KSMA Physician's Placement Service is gaining success in getting many non-scholarship recipients to locate in rural areas.

A report from the U of K Extension Service, entitled, "The Changing Kentucky Population" that out of 66 economically depressed areas, 53 of this number had a loss of population with some counties running as high as 19,000.

A projection of the number of scholarship students that will be entering practice in the next five years, 7 will enter in July, 1960; 17 in July, 1961; 17 in July, 1962; 31 in July, 1963; and 16 in July, 1964.

The committee also received an opinion from Kentucky Attorney General Jo M. Ferguson which should aid in the enforcement of loan agreements signed by recipients. Ferguson said, if a doctor who has received a loan fails to practice in a rural area, the State Board of Health has the right to deny or revoke his license.

New KSMA Members Invited to Luncheon, Sept. 22

The invitation list to the KSMA luncheon honoring new members who have joined the Association since September 1, 1958, has been announced by N. L. Bosworth, M.D., chairman of the KSMA Committee on Public Information and Service.

Doctor Bosworth said the new members would be guests of the Association at the special luncheon scheduled for 12 noon on Tuesday, September 22, in the Louis XVI Room of the Brown Hotel, Louisville.

Tickets were scheduled to be sent to the following physicians as the Journal went to press (listing is by counties):

Bath

E. R. Davis, Owingsville

Bell

Renfro B. Baird, Pineville
W. L. Donham, Middlesboro
Thomas J. Vecchio, Middlesboro
Jesse L. Walker, Middlesboro

Bourbon

M. H. King, Paris
R. T. Tender, Paris

Boyd

W. E. Kozee, Catlettsburg

Boyle

J. W. Ramey, Danville

Bullitt

H. S. Spalding, Shepherdsville

Caldwell

N. H. Talley, Jr., Princeton

Campbell-Kenton

Robert H. Berry, Ft. Thomas
J. W. Braun, Newport
Robert T. Longshore, Covington
Carl B. Rowntree, Alexander



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...WHEN YOU PRESCRIBE NEW

MORNIDINE™

(BRAND OF PIPAMAZINE)

A new drug with specific effectiveness in nausea and vomiting of pregnancy, Mornidine eliminates the ordeal of morning sickness.

With its selective action on the vomiting center, or the medullary chemoreceptor "trigger zone," Mornidine possesses the advantages of the phenothiazine drugs without unwanted tranquilizing activity.

Doses of 5 to 10 mg., repeated at intervals of six to eight hours, provide excellent relief all day. In patients who are unable to retain oral medication when first seen, Mornidine may be administered intramuscularly in doses of 5 mg. (1 cc.).

Mornidine is supplied as tablets of 5 mg. and as ampuls of 5 mg. (1 cc.).

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

NIAMID*

the mood brightener

Lifts the burden of depression... opens the way for a sunnier outlook

New areas of therapy

NIAMID is clinically effective in a broad range of depressive states, including: involutional melancholia, senile depression, postpartum depression, reactive depression, the depressive stage of manic-depressive disease, and schizophrenic depressive reaction.

A wide variety of psychoneurotic depressions seen in general practice also respond effectively to NIAMID. Depression associated with the menopause and with postoperative states, and depression accompanying chronic or incurable diseases such as gastrointestinal and cardiovascular disorders, arthritis, and inoperable cancer, can now be treated successfully with NIAMID.

NIAMID is also strikingly effective for many complaints, mild or severe, vague or well defined, when due to masked depression rather than to organic disease. This masked depression may take the form of guilt feelings, crying spells or sadness, difficulty in concentration, loss of energy or drive, insomnia, emotional fatigue, feelings of hopelessness or helplessness, loss of interest in normal activity, listlessness, apprehension or agitation, and loss of appetite and weight.

While tranquilizers have had some measure of effectiveness in many of these areas, NIAMID now gives the practicing physician a new, safe drug for the specific treatment of depression without the risk of increasing the depressive symptoms.

New safety

NIAMID, in extensive clinical trials, has not been associated with the hepatotoxic reactions observed with the first of the monoamine oxidase inhibitors. These reactions have not been seen with NIAMID.

Acute and chronic toxicity studies show this distinctive freedom from toxicity. Moreover, during the extensive clinical trials of NIAMID by a large number of investigators, not only has no liver damage been reported, but only in a very few isolated instances have hypotensive effects been seen.

The absence of toxicity may be the result of the unique carboxamide group in the NIAMID molecule. This structure may explain why NIAMID is excreted largely unchanged in the urine, with only insignificant quantities of potentially free hydrazine being formed. Previously, where a monoamine oxidase inhibitor had been associated with hepatic toxicity, there was some evidence that substantial quantities of free hydrazine were formed in the body.

Background of NIAMID

A major advance in the treatment of mental depression came with a newer understanding of the influence of brain serotonin and norepinephrine on the mood. Levels of both these neuro-hormones are decreased in animals under experimental conditions analogous to depression; relief of these model depressions is seen with a rise in the levels of both serotonin and norepinephrine.

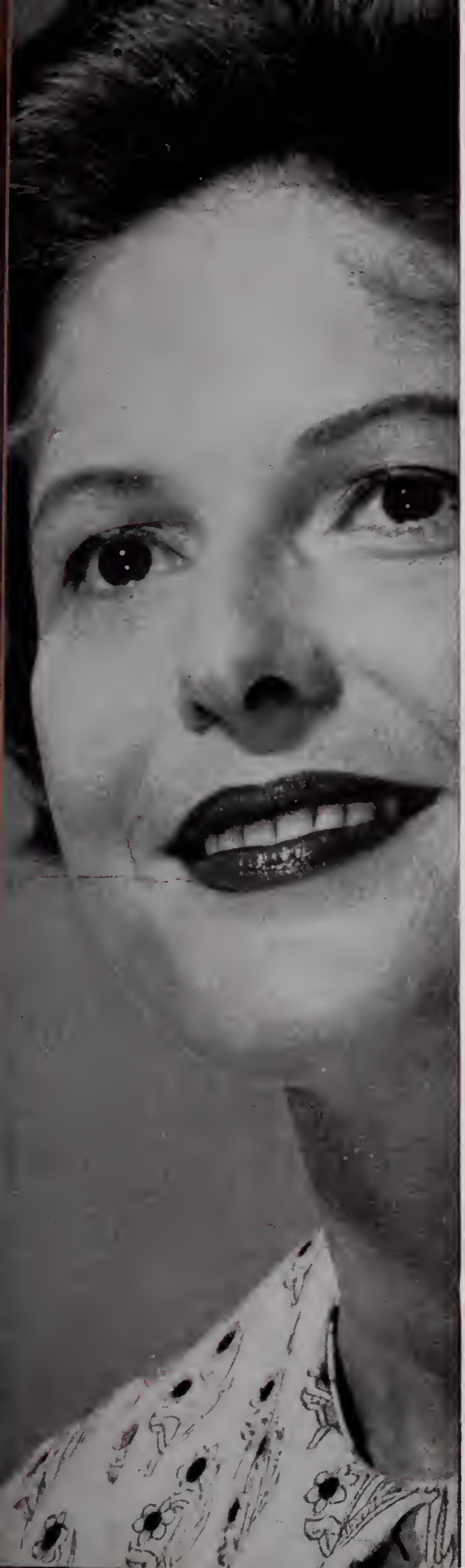
A second advance came with the development of monoamine oxidase inhibitors, substances which raise the cerebral level of both serotonin and norepinephrine. The first of the amine oxidase inhibitors raised the cerebral level of serotonin, but did not appear to raise that of norepinephrine levels proportionately.

Pfizer *Science for the world's well-being*™

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Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

*TRADEMARK FOR BRAND OF NIALAMIDE



Attention at Pfizer Research was then directed to a new drug that would overcome this disadvantage. NIAMID significantly raises the cerebral level of *both* serotonin and norepinephrine under experimental conditions.

The dramatic discovery of NIAMID now makes available an extremely effective, safe antidepressant for the successful treatment of a full range of depressive states.

Precautions

Side effects are most often minor and mild manifestations of central nervous system stimulation, modifiable by reduction in dosage; these may take the form of restlessness, insomnia, headache, weakness, vertigo, dry mouth, and perspiration. Care should be taken when NIAMID is used with chlorothiazide compounds, since hypotensive effects have been noted in some patients receiving combined therapy—even though hypotension has rarely been noted with NIAMID alone. There has been no evidence of liver damage in patients on NIAMID; however, in patients who have any history of liver disease, the possibility of hepatic reactions should be kept in mind.

Dosage and Administration

Start with 75 mg. daily in single or divided doses. After a week or more, revise the daily dosage upward or downward, depending upon the response and tolerance, in steps of one or one-half 25 mg. tablet. Once satisfactory response has been attained, the dosage of NIAMID may be reduced gradually to the maintenance level.

The therapeutic action of NIAMID is gradual, not immediate. Many patients respond within a few days, others satisfactorily in 7 to 14 days. Some patients, particularly chronically depressed or regressed psychotics, may need substantially higher dosages (as much as 200 mg. daily has been used) and prolonged administration before responses are achieved.

Supply

NIAMID is available in: 25 mg., pink, scored tablets in bottles of 100; and 100 mg., orange, scored tablets in bottles of 100.

References

Complete bibliography and Professional Information Booklet are available on request.

*TRADEMARK FOR BRAND OF NIALAMIDE

NIAMID
the mood brightener

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Harold A. Tuch, Covington
Jack C. Wilhoit, Covington

Casey

Lewis E. Wesley, Liberty

Christian

James H. Turner, Hopkinsville
R. S. Vinas, Hopkinsville

Clark

Robert F. Brashear, Winchester
Harold S. Moberly, Jr., Winchester

Clinton

James R. Feild, Albany

Cumberland

Norman K. Kirby, Burkesville

Daviess

R. E. Dawson, Owensboro
Clifton E. Lowery, Owensboro
William A. McManus, Owensboro

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George A. Glenn, Lexington
G. A. Long, Lexington
Kenneth D. McGinnis, Lexington
J. C. McGuire, Lexington
Alfred J. Mueller, Lexington
Dennis B. Penn, Lexington
Thomas G. Perkins, Lexington

Floyd

Leland C. Brown, Wheelwright

Franklin

H. J. Cowherd, Frankfort
D. E. Howard, Frankfort
Carl E. Shroat, Frankfort

Fulton

John W. Ragsdale, Fulton

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Harlan

Robert J. Gosling, Harlan

Hart

David R. Upton, Munfordville

Hopkins

Bruce A. Baber, Madisonville
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George W. Cheek, Jr., Louisville
Douglas David, Louisville
H. William Fister, Louisville
Joseph H. Geyer, New Albany
W. H. Gillespie, Louisville
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Seldon R. Graham, Louisville
Edward C. Graves, Louisville
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W. J. Sandman, Jr., Louisville
C. B. Severs, Lebanon Jct.
Jerry M. Shaw, Louisville
Marjorie K. Smith, Louisville
M. B. Vermillion, Louisville
Edwin H. West, Louisville
Lloyd G. Yopp, Louisville
Martin Zukof, Louisville

LaRue

M. A. Douglass, Jr., Magnolia

Laurel

Alfred E. Jaunzems, London

Logan

Roy B. McEndre, Jr., Lewisburg

McCracken

Martin S. Kleckner, Paducah

McCreary

H. A. Perry, Stearns

McLean

Everett S. Coleman, Sacramento
Samuel E. Scott, Livermore

Monroe

James E. Carter, Tompkinsville

Montgomery

Edwin L. Jones, Mt. Sterling
Lou E. Roberts, Mt. Sterling

Muhlenberg

James N. Tulloh, Central City

Rockcastle

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Russell

James E. Monin, Jamestown

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Robert Wheeler, Georgetown

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Lewis R. Sutton, Elkton

Washington

Harold B. Simms, Springfield

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Henry H. Bunch, Williamsburg

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Miltown®+conjugated estrogens (equine)

Supplied in two potencies for dosage flexibility:

MILPREM-400, each coated pink tablet contains 400 mg. Miltown (meprobamate) and 0.4 mg. conjugated estrogens (equine).

MILPREM-200, each coated old-rose tablet contains 200 mg. Miltown and 0.4 mg. conjugated estrogens (equine).

Both potencies in bottles of 60.

Literature and samples on request.

In minutes, Milprem starts to ease anxiety and depression. It relieves insomnia, relaxes tense muscles; alleviates low back pain and tension headache. As the patient continues on Milprem, the replacement of estrogens checks hot flushes and other physical symptoms.

Easy dosage schedule: One Milprem tablet t.i.d. in 21-day courses with one-week rest periods; during the rest periods, Miltown alone can sustain the patient.

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CMP-9224-69

Digest—Of The Open Meeting Of The KSMA Council on July 30, 1959

The report of the President, the Secretary and the Delegates to the AMA, were presented (See August issue of the Journal for a detailed account of the AMA Annual Meeting of the House of Delegates in June, 1959).

The Legislative Committee report was given by the Chairman for State Affairs, Wyatt Norvell, M.D. He stated that apparently the Forand Bill (HR 4700) was shelved for this session of the Congress, and that the efforts of Carl Fortune, M.D., in testifying before the House Ways and Means Committee on July 17 had been effective. The new legislative key man system was explained and praise was given J. Farra Van Meter, M.D., Lexington, for his work in connection with resisting the Forand Bill. The meeting with the gubernatorial candidates earlier in the week was also described by Doctor Norvell.

Indigent Care

Status of the indigent care legislation was described by Doctor Troutman. It was pointed out that all members of the Council on Allied Medical Service had agreed on an indigent care bill and that the proposal was now being reviewed by the Legislative Research Commission.

The Council then decided to support legislation that would provide funds for compulsory vaccination and referred a request for a study on priviledged communications to a special committee.

PG Education

The report of the Committee on Postgraduate Medical Education was given by Walter Coe, M.D. It was pointed out that part of the increase in dues voted by the 1958 session of the House of Delegates had been earmarked for the postgraduate medical education program. This was voted after this Committee, a year ago, had presented a proposal estimated to cost approximately $10,000 a year.

The question of whether relative value studies should be conducted in this state was debated at some length and it was eventually decided to send the necessary information to local county medical societies and ask that the societies report on the desirability of whether or not the KSMA should conduct such a study.

The report of the KSMA Advisory Commission to Blue Shield was presented by W. Vinson Pierce, M.D., chairman of the Commission. It was pointed out that his Commission had been asked to prepare a special contract for the aged and also to develop a service type coverage for consideration by this Council. Actual presentation of the Commission's recommendations was made by Mr. Don Giffen of the Kentucky Blue Shield Plan at the request of Doctor Pierce. Following a lengthy discussion, it was decided to distribute more information on the pros and cons of service type coverage and consider it at a special meeting of the House of Delegates following the Annual Meeting.

Coverage for Aged

Immediately after this action was taken, the Council authorized the KSMA Advisory Commission to Blue Shield to proceed with the development of a special indemnity type old age coverage for implementation.

Following comments by the Commissioner of Health, the Council voted to ask the Legislative Committee and the Association's attorney to review the Medical Practice Act, with respect to making adjustments in connection with the limited license provision. The Council heard a request from the Gibbs-Inman Company for an increase of 5 per cent in billing to the Association for printing the Journal. It was felt that this increase was indicated due to rising labor costs and paper charges.

The Council voted to grant the increase.

Editors' Meeting

The suggestion that the KSMA invite the 1960 meeting of the Southeastern Medical Editors Conference to Louisville was approved. The request of the Medicare Review Committee that the Committee's make-up be slightly revised was approved and the Council accepted the change in Bylaws of the proposed Kentucky Health Council.

Doctor Coe said that present plans call for getting a full time coordinator, a secretary and the opening of an office. The University of Louisville and the University of Kentucky are cooperating substantially with the project. The Council voted to implement the program and make the necessary funds (not to exceed $10,000) available.

**As authorized by the 1956 session of the House of Delegates, the Journal is presenting a digest of the minutes of the July 31 meeting of the Council of the KSMA.*


Remarkable
relief from
low back pain and
dysmenorrhea
Trancopal
THE FIRST TRUE TRANQUILAXANT

Here is

can expect

prescribe

for low back pain

case profile no. 2758*

A middle-aged man had intermittent low back pain attributed to injuries received in an automobile accident three years ago. The pain radiated down both legs, making the patient walk bent over. He also had difficulty in getting out of bed and had to pull his knees up and roll out. Any heavy lifting precipitated a new attack, and he tired easily.

Findings on x-ray of the thoracic and lumbar spine were negative. All other laboratory studies were within normal limits. A herniated disc, though still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics, steroids (without success), and narcotics during severe attacks.

On a dosage of Trancopal, 100 mg. t.i.d., this patient is able to walk around almost normally and carry on his regular activities as long as he does not overdo. He has received Trancopal for over seven months with excellent relief of symptoms. There have been no side effects.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*



what you when you

THE FIRST TRUE TRANQUILAXANT

Trancopal®

for dysmenorrhea
and premenstrual tension



case profile no. 3347*

A 35-year-old housewife had a history of severe dysmenorrhea and premenstrual tension. Menarche occurred at the age of 14. She is a gravida 2, para 1. Her menstrual cycle is fairly regular, and previous medical history indicates no apparent abnormalities. Findings on pelvic examination were negative. Severe tension and irritability routinely occurred from two to seven days before and during menstruation. Cramping was experienced for all three days of the menstrual period. Analgesic preparations provided limited symptomatic relief.

Trancopal, 200 mg. t.i.d., was prescribed for dysmenorrhea. It not only has relieved the severe cramping, but has provided a welcome relief from the irritability accompanying it. Because of these excellent results, Trancopal also was prescribed for her tenseness during the premenstrual period with a most gratifying response.

This patient has successfully remained on the above regimen for over six months without adverse effects.

Turn Page for Complete Listing of Indications and Dosage

THE FIRST TRUE TRANQUILAXANT

Trancopal

potent muscle relaxant

effective tranquilizer

- In musculoskeletal disorders, effective in 91% of patients.[1]
- In anxiety and tension states, effective in 88% of patients.[1]
- Low incidence of side effects (2.3% of patients). Blood pressure, pulse rate, respiration and digestive processes unaffected by therapeutic dosage. No effects on hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications:

Musculoskeletal:
Low back pain (lumbago, etc.)
Neck pain (torticollis, etc.)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow, etc.
Myositis
Postoperative muscle spasm

Psychogenic:
Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism

Now available in two strengths:

Trancopal Caplets®:
100 mg. (peach colored, scored), bottles of 100.

New Strength

Trancopal Caplets:
200 mg. (green colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

1. Collective Study, Department of Medical Research, Winthrop Laboratories.



Winthrop LABORATORIES
New York 18, New York

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S Pat. Off. Printed in U.S.A. 8-59 (1385 AM)

Student AMA

A new correspondent welcomes you to another medical school year. It certianly is hoped (by others than myself, I'm sure) that this column measures up to that of last year's done so capably by Neville Caudill. Doctor Caudill, as many of you know, is interning at the Public Health Service in Baltimore, Md.

Reviewing the accomplishments of last year would be a voluminous task, but a few of these might be of interest to you.

The student - physician advisory program, although in its infancy, was well received by most of its participants. The intention of the program, as many of you well know, is to acquaint the medical school freshman with a volunteer doctor from the Jefferson County Medical Society who acts as a friend during the four years of the student's schooling. Questionnaires to last year's participants showed an overwhelming desire for the program on both student and physician level.

The University of Louisville recognized the merger of the student council of the medical school with the Student American Medical Association. This combined the two groups into a more effective governing body which is now known as the University of Louisville Chapter, SAMA.

During the National SAMA Convention held in Chicago in May of this year, the University of Louisville Chapter was recognized and commended on both the student - physician advisory program and the merger of school council and SAMA. Your organization, the KSMA, graciously made the trip available to four members of U of L by contributing $150. The students attending considered the convention well worthwhile, as ideas from students of medical schools throughout the country were exchanged.

Our plans for this year are extensive and numerous. Among these are school spirit improvement, a monthly medical school newsletter, a series of night programs for both students and their friends, and an orientation program for incoming freshmen.

We would appreciate greatly any suggestions or criticisms that might contribute to our activities. Please do not hesitate to contact us if you have any constructive ideas. All of us desire to be proud alumni of a great medical school.

Robert K. McKechnie
U. of L. Chapter, S.A.M.A

Missouri Cancer Conference Set

The sixth annual Southeast Missouri Cancer Conference, designed for physicians in Western Kentucky, Southern Illinois, Northern Arkansas, Northwestern Tennessee, and Southeastern Missouri, is scheduled for Cape Girardeau, Mo., on Sunday, October 4. Subjects included in the session will deal with thyroid diseases, office diagnosis and procedures, isotopes in diagnosis and treatment and lesions of distal bowel.



Three key figures in the Athletic Injury Prevention Conference in Lexington on August 12 talk things over before the program's start. From left to right are—Bernie Shively, director of Athletics, University of Kentucky; Carroll L. Witten, M.D., Louisville, chairman of the KSMA School Health Committee who presided; and Ted Sanford, Commissioner of the Kentucky High School Athletic Association.

1959 Association Dues Survey Results Reported

A check of a recent survey of annual membership dues paid by members of state medical associations showed that Kentucky is one of 10 states where dues are $50 a year.

An analysis revealed that 17 states had set their dues above $50 a year and that all but five of these were smaller states. Physicians in Nevada pay $145 a year and physicians in Utah, $120 a year.

The survey was made by a firm of consultants that specializes in office management, consulting, surveys for trade, professional and non-profit organizations—Rogers, Slade & Hill of New York City.

Results of the June, 1959 survey follow:

Alobomo	$ 50*	Nebroska	$ 35
Arizono	95	Nevado	145
Arkonsos	30	New Hompshire	50*
Colifornio	75	New Jersey	30
Colorodo	85	New Mexico	70
Connecticut	33	New York	25
Delowore	50*	North Corolino	50*
District of Columbio	50*	North Dokoto	75
Florido	40	Ohio	30
Georgio	40	Oklohomo	67
Howoii	39	Oregon	50*
Idoho	82	Pennsylvonio	40
Illinois	75	Rhode Islond	50*
Indiono	50*	South Corolino	60
Iowo	85	South Dokoto	75
Konsos	40	Tennessee	25
Kentucky	50	Texos	45
Louisiono	50*	Utoh	120
Moine	55	Vermont	45
Morylond	60	Virginio	25
Mossochusetts	35	Woshington	45
Michigon	60	West Virginio	28
Mississippi	75	Wisconsin	75
Missouri	35	Wyoming	25
Montono	78.50		

*Hoving the same dues os Kentucky.



Participating in a panel on the Responsbility for the Prevention of Athletic Injuries at the recent conference in Lexington were:—(left to right)—Frank Ramsey, Madisonville, of the Boston Celtics; John "Rusty" Payne, trainer at the U of K; O. B. Murphy, M.D., Lexington; Joe Ohr, principal and coach, Irvine High School; and moderator, Bernie Shively, director of athletics, U of K.

Month's Clinic Schedule Released by Children's Commission

The Kentucky Crippled Children Commission offers services to children whose parents are indigent or unable to pay total amount of care, according to Medical Director Marjorie K. Smith, M.D.

Since children are referred according to districts it is important that appointments be made through Kentucky Crippled Children Commission, P. O. Box 65, Shelby Station, Louisville or Out-Patient Department, Kentucky Crippled Commission, c/o Cardinal Hill Convalescent Hospital, Versailles Pike, Lexington. Patients suffering from cleft lip and palate or cerebral palsy are only admitted to clinics after having been seen and evaluated.

Following is a list of regular clinics scheduled for the remainder of the month.

Louisville District

Kosair Crippled Children Hospital

Sept. 15	Orthopedic Clinic
Sept. 16	Cerebral Palsy
Sept. 18	Scoliosis
Sept. 25	Orthopedic

Lexington District

Out Patient Department—Cardinal Hill Convalescent Home

Sept. 17	Plastic Surgery
Sept. 18	Orthopedic
Sept. 23	Cerebral Palsy
Sept. 25	Orthopedic

Covington District

Treatment Center, Covington

Sept. 23	Cerebral Palsy

Ashland District

King's Daughter Hospital

Sept. 29	Orthopedic

Field Clinic

Corbin Clinic, First Christian Church. District Includes Knox, Laurel, and Whitley Counties

Sept. 17

Drs. Haller and Murray on Staff of U of L Medical School

J. Alex Haller, M.D., and Marvin Murrary, M.D., have recently joined the faculty of the University of Louisville School of Medicine. Doctor Haller is the first Price fellow in surgical research and Doctor Murray is the new clinical director of laboratories at General Hospital and assistant professor of pathology at the medical school.

A native of Pulaski, Va., Doctor Haller graduated from Johns Hopkins Medical School in 1951. He interned at Johns Hopkins and took training in pathology at Zurich, Switzerland. From 1955-9 he took a surgical residency at Johns Hopkins. He was in the U. S. Public Health Service—Coast Guard. Most of his service career was spent in cardiovascular research at the National Heart Institute, Bethesda, Md. The Price fund, which will eventually total $300,000 was set up by John W. Price, Jr., a retired Louisville surgeon, and Mrs. Price two years ago.

Doctor Murray, a graduate of Wayne University with an M.D. degree in 1955, interned at Mt. Sinai Hospital, Milwaukee, and took his residency training in pathology at the University of Wisconsin. A pathologist, he has done considerable research, mainly on blood coagulation and has had several scientific articles published. He is a native of Milwaukee.

AMEF Notes M.D. Response to Direct Requests

The American Medical Education Foundation recently indicated that physicians respond more satisfactorily to an appeal for a gift in terms of specified amounts, rather than vague requests to "give to AMEF."

For example the Pennsylvania House of Delegates has for several years passed a resolution asking for a $25 contribution from each physician. Most physicians sent checks for the specified $25. In New York, a voluntary dues increase of $10 is responded to by gifts of $10.

In Texas, the AMEF 1957 chairman requested $35 from each physician and reported that most gifts matched or exceeded the request. A mailing in Alaska mentioned that the average AMEF gift was $33. In reply physicians sent checks for $33 even though a specific request was not made. The average in Minnesota arrived at by dividing the number of physicians into a predetermined state goal is generally close to $30.

PG Opportunities in Kentucky Listed by Committee

A listing of postgraduate medical opportunities available in Kentucky during the final quarter of 1959 has been announced by Walter Coe, M.D., Louisville, chairman of the KSMA Committee on Postgraduate Medical Education.

Doctor Coe urged all KSMA members to take advantage of the PG offerings for October, November, and December which are listed below.

October

14 Postgraduate Symposium, TB Hospital, Madisonville, in cooperation with KSMA's 1st, 2nd, and 3rd Councilor Dists., KAGP, and Kentucky State TB Hospital Commission

21-22 Annual Fall Clinical Conference, Lexington Clinic, 1221 South Broadway, Lexington, Wednesday, October 21—10:00 a.m. to 5:00 p.m., Thursday, October 22, 9:00 a.m. to 12:00 noon.

22 Postgraduate Seminar, Kentucky Academy of General Practice, Kenlake Hotel, Hardin

29 Postgraduate Seminar, District 5 State TB Hospital, in cooperation with KSMA and KAGP, 3 p.m.

31 Regional meeting, American College of Physicians for Ky. and Tennessee, Hermitage Hotel, Nashville, Tenn., 9 a.m.

November

5 Seminar on Alcoholism, planned by Kentucky Commission on Alcoholism in cooperation with other health groups, Brown Hotel, Louisville

12 Postgraduate Seminar, Kentucky Academy of General Practice, Campbellsville

December

12 Kentucky Society of Pathologists, Lafayette Hotel, Lexington, 3 p.m., KSMA members cordially invited to stay for dinner as paying guests

17 John N. Norton Memorial Infirmary, Medical Seminar, Louisville 9 a.m.—Free lunch

U of L '58 Graduates Licensed to Practice in Ky.

Forty-five members of the 1958 University of Louisville Medical School class recently received their licenses to practice in Kentucky, according to an announcement from Russell Teague, M.D., Commissioner of Health.

Following are the new licentiates:

Ed. M. Bowles, Jr., M.D. Louisville
Irvin E. Bronner, M.D. Louisville
Martin Zukof, M.D. Louisville
Olney M. Patrick, M.D. Louisville
T. W. Demunbrun, M.D. Louisville
Victor Jenkins, M.D. Lakeland
Wm. D. Hatfield, M.D. Irvington
James W. Roney, M.D. Lebanon Junction
Harry G. Caldwell, M.D. Williamstown
P. D. Hitchcock, M.D. Upton
Robt. C. Burkhart, M.D. Harlan
David R. Upton, M.D. Munfordville
Chas. R. Cambron, M.D. Louisville
T. E. Campbell, M.D. Louisville
Max Ervin, M.D. Louisville
Bryant A. Bloss, M.D. Louisville
J. T. Flowers, M.D. Taylorsville
Carroll C. Brooks, M.D. Bowling Green
Henry H. Bunch, M.D. Williamsburg
Dale H. Farabee, M.D. Louisville
N. S. Fisher, Jr., M.D. Midway
William R. Fuqua, M.D. Louisville
N. W. Glaser, Sr., M.D. Louisville
James E. Hamilton, M.D. Louisville
William J. Hanley, M.D. Beaver Dam
Robert L. Keisler, M.D. Louisville
Theo. N. Lynch, M.D. Louisville
William O. Massey, M.D. Hazard
Everett T. Mays, M.D. Louisville
D. H. Moseley, M.D. Lyndon
J. L. Nicholson, M.D. Louisville
Jack W. Owens, M.D. Louisville
John J. Ryan, Jr., M.D. Louisville
David W. Scott, M.D. Louisville
Charles B. Severs, M.D. Valley Station
James F. Siles, M.D. Covington
Mary A. Smith, M.D. Louisville
E. F. Smock, Jr., M.D. Louisville
J. P. Sutherland, M.D. Louisville
James D. Telfer, M.D. Louisville
G. G. Temofeew, M.D. Louisville
Lewis E. Wash, M.D. Lawrenceburg
J. J. Wernert, Jr., M.D. Louisville
M. A. Winchester, M.D. Whitley City
H. C. Anderson, M. D. Louisville

Interstate Scientific Meet Planned

The annual assembly of the Interstate Postgraduate Medical Association of North America has planned its 44th Scientific Assembly at the Palmer House in Chicago on November 2-5. Featured speaker at the banquet on Wednesday, November 4, will be Kenneth MacFarland, Ph.D., Topeka, Kans., who KSMA members will remember as a speaker at the 1957 President's Luncheon.

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References: 1. Menger, H. C.: Clin. Med. 4:313 (March) 1957. 2. Charles, C. M.: Geriatrics 2:110 (March) 1956. 3. Shuster, B. H.: M. Clin. North America 40:1787 (Nov.) 1956. 4. Dolowitz, D. A.: Rocky Mountain M. J. 55:53 (Oct.) 1958.

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Questions from the audience to members of a panel on the "Prevention and Recognition of Injuries" at the KSMA's Athletic Injury Prevention Conference were referred to panel members by moderator Carroll L. Witten, M.D. (left). Panel members include: Paul J. Ross, M.D., John M. Moorhatch, M.D., and Charles F. Wood, M.D., all of Louisville.

Civil Defense Conference Set

The 10th annual county medical societies Civil Defense Conference will be held in Chicago's Morrison Hotel on November 7-8. Sponsored by the American Medical Association's Council on National Defense, the purpose of the Conference is to inform and assist medical and health personnel for their roles in the event of a disaster.

Featured speaker will be Congressman Melvin Price (D-Ill.) who is ranking member of the Joint Congressional Committee on Atomic Energy. He will report on recent findings on the environmental and biological effects of nuclear warfare. Carl J. Sprink, M.D., Detroit is conference chairman. More information may be obtained by contacting Mr. Frank W. Barton, Secretary, Council on National Defense, American Medical Association, 535 N. Dearborn, Chicago 10, Ill.

Dr. Wheeler Takes Research Post

Norman Wheeler, M.D., who has practiced in Berea since 1951, has accepted a position on the Medical research staff of Abbott Laboratories in North Chicago, Ill. A native of Lawrence County, Doctor Wheeler graduated from the Medical College of Georgia receiving his M.D. degree in 1950 and interned at St. Joseph Hospital, Lexington. Before receiving his medical degree he had taught physiology for four years at Hahnemann Medical College in Philadelphia and later was a fellow of the Physiology Department of the University of Georgia Medical School where he spent two years in heart research.

Children's Rejoins Community Chest

Children's Hospital in Louisville has rejoined the Community Chest. The hospital had originally voted to withdraw from the Chest in March of this year and conduct its own $550,000 fund drive. After several board meetings in which the possibility of rejoining was discussed and rejected; the Board of Directors of the Hospital voted unanimously to rejoin the Chest at a meeting on July 15. In announcing the Board's decision Albert F. Reutlinger said, "I am certain that the chest will reach its goal and that the hospital and community will benefit thereby."

100 Attend KAGP Seminar

One hundred physicians attended the Lexington Seminar of the Kentucky Chapter American Academy of General Practice on Sunday, August 16. Principal speaker was Herbert W. Salter, M.D., Cleveland, director of the American Academy of General Practice. The scientific portion of the program included Harold W. Baker, M.D., and O. James Hurt, M.D., Louisville; and Richard F. Shapiro, M.D., of the University of Pennsylvania, and Richard W. Payne, M.D., University of Oklahoma. Robert M. Circle, M.D., Lexington, was seminar chairman. Another feature of the program was a style show for the 70 wives of physicians who attended.

M. D. Contributions Exceed Quota

As the Journal went to press, physicians had exceeded the $250,000 quota they set for themselves in contributions to the University of Louisville Development Fund by $14,167, according to R. Glen Spurling, M.D., Louisviille, chairman of the drive's medical committee.

Doctor Spurling reported that 119 physicians and dentists had joined the $1,000 Club by contributing $1,000 or more to the program. Members of the "Club" will receive a certificate and it is planned to have a plaque listing the members in the new medical-dental research building. A total of $2,290,-536 has been pledged to the program which has a goal of $2,489,585. Of that total, $1,485,585 is earmarked for construction of the research building and the first phase of a cancer-treatment center.

Symposium on Injuries Planned

A Symposium on the Therapy of Acute Injuries is planned for Wednesday, October 7, in the auditorium of the Allen Memorial Medical Library in Cleveland, Ohio. The symposium is sponsored by the Council on Drugs of the American Medical Association in cooperation with the Academy of Medicine of Cleveland and Cuyahoga County Medical Society, the Western Reserve University School of Medicine, the Ohio State Medical Association and the Ohio Committee on Trauma of the American College of Surgeons.

50 At Henderson KAGP Seminar

Fifty physicians attended the postgraduate seminar of the Kentucky Academy of General Practice in Henderson on July 30, according to Robert L. Sumner, M.D., Henderson, seminar chairman.

The program which included talks by James Kirtley, M.D., Nashville, Tenn.; David Adler, M.D., Columbus, Ind.; Eugene Countiss, M.D., New Orleans, La.; and George W. Pedigo, Jr., M.D., Louisville, was acceptable for four hours of Category 1 credit in the AAGP.

Dr. Willard to Attend AMA Conf.

William R. Willard, M.D., Lexington, dean of the University of Kentucky College of Medicine, will be among 19 of the nation's leading scientists who will meet with the AMA's Board of Trustees and staff executives from Sept. 14-16 in Hershey, Pa., to examine the scientific activities of the AMA.

It is the first such meeting in the history of the AMA. Edward L. Turner, M.D., director of the AMA's Division of Scientific Activities expressed the hope that "some definite suggestions and recommendations from this conference as to how the AMA can be most productive in the area of scientific activities will be developed at the conference." Meeting with the invited scientists and AMA trustees will be chairmen and secretaries of AMA's Councils on Medical Education and Hospitals, Scientific Assembly, Mental Health, Drugs, Foods and Nutrition, and Medical Physics.

Conf. on Med. Education Held

Educators from 61 different countries met in Chicago's Palmer House for the Second World Conference on Medical Education from August 31 to September 4. One hundred twenty-five speakers from every part of the world, including Russia, delivered scientific papers.

Sponsored by the World Medical Association with the World Health Organization, the Council for International Organizations of Medical Sciences, and the International Association of Universities, the conference sessions were conducted with simultaneous translations into English, French, and Spanish.

KAGP Planning Two PG Seminars

Two postgraduate medical seminars are planned by the Kentucky Academy of General Practice for the Fall months, according to Daryl P. Harvey, M.D., Glasgow, KAGP president.

First seminar will be at Kenlake State Park in Hardin on October 22. Joseph R. Miller, M.D., Benton, is chairman. On November 12, another seminar will be held at Campbellsville. Roy G. Wilson, M.D., Campbellsville, is chairman of the Campbellsville seminar. Full details on the seminars were not available at press time, but will appear in the October issue of the Journal.

UK Plans Dental School

The State will award a contract in early November for construction of a $2,500,000 dental school at the University of Kentucky Medical Center. Final plans for the facilities will be submitted around October 10 by Meriweather and Marye, Lexington architects. William R. Willard, M.D., vice president of the Medical Center said the wing will accommodate about 50 students a class, making a total of 200 for the four-year program. The wing will also include "considerable space for research in dental science," Dean Willard said.

News Items

Charles N. Tarkington, M.D., a native of Moreland, has joined the Lexington Clinic staff where he will limit his practice to obstetrics and gynecology. Doctor Tarkington, who graduated from the University of Louisville School of Medicine in 1953, has just completed his residency training at St. Louis City Hospital. He interned at St. Louis City Hospital from 1953-4 and was in general practice in Fayetteville, Ark., before starting his specialty training in 1956.

Norbert J. Weber, M.D., a native of Ohio, has joined the surgical staff of the District 2 State TB Hospital in Louisville. He is a graduate of Loyola University in Chicago in 1951. Doctor Weber interned at Mercy Hospital in Toledo in 1951-2 and took his residency training at Indianapolis General Hospital.

Lon William O'Bannon, M.D., has joined the Elizabethtown Clinic where he will limit his practice to internal medicine. Doctor O'Bannon, a native of Mississippi, graduated from the University of Tennessee School of Medicine in 1948. He interned at Crawford W. Long and Emory University Hospital and took his residency at the University of Iowa, Medical College of Virginia, and Memphis Veterans Medical Teaching group hospital.

Captain James B. Carty, Richmond, has been appointed commander of the Air Force 337th TAC Hospital at Shaw Air Force Base, S. C. Captain Carty, a graduate of the University of Louisville School of Medicine, at 29 and with only two years of military service, is one of the youngest hospital commanders in the Air Force.

E. Franklin Hall, M.D., has resigned as Ashland-Boyd County Health officer, effective September 1. He is entering the University of Michigan to work on his master's degree in public health.

Hobart Lester, M.D., Louisa, has accepted a fellowship in anesthesia at the Cleveland Clinic, Cleveland, Ohio. Doctor Lester, a graduate of the University of Louisville School of Medicine in 1946 interned at St. Mary's Hospital, Huntington, W. Va. He had practiced in Louisa since 1947 except for 1948-50 when he was in the U. S. Air Force.

The hobby of retired physician, Fergison Doyle, M.D., Winchester, was written up in the *Lexington Herald.* Doctor Doyle, who is 81, spends his leisure hours with a hobby of history and collecting. He recently donated a large collection of Clark County historical works to the Winchester Public Library. He has a collection of about 500 portraits, including one of the late Ephraim McDowell, M.D., Danville, who performed the first oophorectomy in 1809.

October 4-10 has been proclaimed National Fire Prevention Week by President Eisenhower. In Louisville the week will be observed through the Fire Prevention Council in cooperation with the Louisville Division of Fire and over twenty local organizations. The Council maintains a year-around activity in its efforts toward fire prevention and protection. Fire Prevention Week is the highlight of this activity.

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5-273



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News Items

Paul E. Davis, Jr., M.D., was recently named chief of the Out-Patient Department at Western State Hospital in Hopkinsville. A native of Paducah, he graduated from the University of Louisville School of Medicine in 1952. He interned at V. A. Hospital in Long Beach, California, and took three years of residency training at Central State Hospital, Norman, Okla. He became Board eligible in 1958. He had three years of psychiatric experience at Central State Hospital in Norman, Oklahoma, plus his residency training there.

Edsel H. Burton, M.D., has returned to practice in Faubush, where he will engage in general practice. He had just completed a two-year tour of duty as a major in the U. S. Army Medical Corps. Before that he had been in practice for 10 years. Doctor Burton is a 1946 graduate of the University of Louisville School of Medicine and a native of Bud, Kentucky.

Millard A. Shepherd, M.D., has located in Somerset, where he will serve as health officer for Pulaski, McCreary, and Laurel counties. Doctor Shepherd graduated from the University of Louisville School of Medicine in 1953 and interned at Kentucky Baptist in Louisville. He has just completed a year of study at the University of North Carolina School of Public Health, where he received his master's degree in public health. He practiced in Harrodsburg in 1954-56 and was public health officer in Henderson from 1956-58.

Jack A. Schecter, M.D., has joined the staff of Jewish Hospital in Louisville where he will limit his practice to anesthesiology. He will be associated in practice with S. H. Mann, M.D., and W. Ash, M.D. A graduate of Indiana University School of Medicine in 1954, he interned at Los Angeles County Harbor General Hospital in Torrance. He took his residency training at Los Angeles Veterans Administration Center, Los Angeles. Doctor Schecter just completed a tour of duty with the U. S. Navy at Great Lakes, Chicago, Illinois.

Donald G. Diebold, M.D., has opened an office in Louisville for the general practice of medicine. Doctor Diebold is a 1956 graduate of the University of Louisville. He interned at SS. Mary and Elizabeth Hospital in Louisville and has just completed a tour of duty with the U. S. Army at Roanoke, Virginia.

William F. Hohn, M.D., has been assigned by the U. S. Public Health Service to work for two years in venereal disease programs in Kentucky, according to Patricia K. Conlan, M.D., director of the Kentucky State Department of Health's Bureau of Medical Services. A native of Los Angeles, Doctor Hohn is a graduate of Creighton University School of Medicine, Omaha, and interned at Sacramento County Hospital, Sacramento, Calif. He also received special training in venereal disease control at the Communicable Disease Center, Atlanta, Georgia.

John A. Wilson, M.D., has started general practice in Brownsville, Kentucky. A native of Kirbyville, Texas, he is practicing in association with Marcus B. Wilkes, M.D. Doctor Wilson graduated from the University of Louisville in 1956 and interned at the Naval Hospital in Portsmouth, Va.

H. L. McPheeters, M.D., Kentucky mental-health commissioner, has been named to a 12-member committee on planning for mental-health facilities throughout the nation. Named by Surgeon General Leroy E. Burney, the group will help the U. S. Public Health Service draw up treatment and administrative guides for mental hospitals.

William J. Hanley, Sr., M.D., has opened an office for the general practice of medicine in Beaver Dam. He is practicing in association with **Oscar Allen, M.D., and Willard F. Chumley, M.D.** A 1958 graduate of the University of Louisville Medical School, Doctor Hanley interned at St. Joseph's in Flint, Mich.

Wreno M. Hall, M.D., who previously was in general practice in Mt. Sterling, has opened an office in Louisville for the practice of general surgery. Doctor Hall graduated from the University of Louisville School of Medicine in 1950, interned at Good Samaritan Hospital, Lexington, and took his residency training at the VA Hospital. Doctor Hall is a native of Cecilia.

A'bert B. Harris, M.D., has located in Louisville where he will limit his practice to obstetrics and gynecology. He is a 1955 graduate of Meharry Medical College, interned at St. Margaret Hospital, Hammond, Ind., took his residency at Meharry Medical College Hospital. Doctor Harris is a native of Louisiana.

Norman Fisher, M.D., is practicing in Midway in association with **Ben Roach, M.D.** A Louisvillian, he graduated from the University of Louisville in 1958 and interned at Louisville General Hospital.

Nicholas Z. Kafoglis, M.D., a native of Lexington, has started the general practice of medicine at the Graves-Gilbert Clinic in Bowling Green. He is a graduate of the University of Pennsylvania Medical School in 1956, interned at Ohio State University, and was a captain in the USAF(MC) from 1957-59.

Fred Pipkin, M.D., has opened an office in Louisville where he will limit his practice to pediatrics. A graduate of Vanderbilt University Medical School in 1952, he interned at Louisville General Hospital, and took residency training at Louisville General and Vanderbilt Hospital. He was born in Lafayette, Tennessee.

Philip D. Hitchcock, M.D., a 1958 graduate of the University of Louisville School of Medicine, has started the general practice of medicine at Upton. He interned at St. Elizabeth Hospital in Dayton, Ohio.

Henry H. Bunch, M.D., a native of Whitley County, has located in Williamsburg where he will engage in the general practice of medicine. A 1958 graduate of the University of Louisville School of Medicine, Doctor Bunch has completed his internship training at St. Elizabeth Hospital, Dayton, Ohio.

William D. Hatfield, M.D., has started general practice in Irvington in association with **William H. Brown, M.D.**, A graduate of the University of Louisville School of Medicine in 1958, he interned at St. Joseph Infirmary in Louisville.

Margaret G. Smythe, M.D., a native of Nanking, China, was scheduled to start school health work in Lexington. She will be affiliated with Transylvania College in a part time capacity. Doctor Smythe graduated from Rush Medical College in 1926 and interned at North Chicago Hospital. From 1928-51 she did school health work in Nanking, China, and was at Berea College from 1952-59.

Arvids H. Klavins, M.D., has joined the staff of the Central State Hospital in Lakeland. A native of Latvia, Doctor Klavins graduated from the State University Medical School in Riga, Latvia in 1928. He was at Western State Hospital, Hopkinsville, for 4½ years and prior to that was in general practice in Latvia, Germany, and Australia.

Oliver M. Reynolds, M.D., Louisville, a graduate of Meharry Medical College in Nashville in 1909, was honored during the June commencement exercises of his alma mater for his devotion to humanity. Doctor Reynolds received the president's award in the form of a gold-plated plaque inscribed to "Dr. Oliver M. Reynolds for 50 years of service to mankind." Doctor Reynolds has been in general practice for 50 years.

Douglas David, M.D., has opened an office in Louisville where he will limit his practice to internal medicine. Doctor David, a native Louisvillian, graduated from the University of Louisville School of Medicine in 1952. He interned at Michael Reese Hospital and took his residency training at Hines VA Hospital, Hines, Ill. Following completion of his residency, he was director of the cardiopulmonary laboratory at Hines VA Hospital.

Walter C. Shea, Jr., M.D., has joined the staff of Mayfield Hospital and Clinic in Mayfield as a general practitioner. Doctor Shea graduated from the University of Tennessee Medical School in 1956 and took his internship and 2 years of residency training at St. Thomas Hospital in Nashville.

William Kelly Skaggs, M.D., a native of Louisa, has opened an office for the general practice of medicine in Taylorsville. Doctor Skaggs graduated from the University of Louisville School of Medicine in 1955. He took his internship training at St. Joseph Infirmary in Louisville form 1955-6. He served as a Lieutenant in the U. S. Navy from 1957-9.

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In Memoriam

GEORGE L. THOMPSON, M.D.

Owensboro

1878-1959

George L. Thompson, M.D., general practitioner and former Owensboro City physician, died at Owensboro-Daviess hospital on August 10. Doctor Thompson was a native of Melber in McCracken County. He was 81.

He attended old West Kentucky College in Mayfield and received his medical degree from the University of Louisville in 1907. In 1909 he moved to Lovelaceville and practiced there until he entered the Army Medical Corps in 1918. Later he practiced at Wickliffe until 1927 when he was in public health work in Mississippi. In 1930 he returned to Owensboro as Public Health Office and served there until 1933 when he moved to McLean County. He returned to Owensboro in 1935 and had served as City physician until recently.

Committee Reports

Committee on Scientific Assembly and Arrangements

Robert W. Robertson, M.D., chairman

Louisville **July 23**

Plans for the 1959 Annual Meeting were completed. Reports of the associate committees having to do with the meeting were read and approved.

The committee voted to develop a new system in setting up the 1960 scientific program which is designed to make the meeting more profitable.

Committee to Study Relations with Voluntary Health Groups

Ralph Denham, M.D., Louisville, chairman

Louisville **July 23**

It was the unanimous opinion of the committee that all KSMA members should interest themselves in voluntary health organizations at both the state and local level as effective physician-participation is not only expected by the public, but doctors have much to contribute both in the interest of the organization and the advancement of their respective fields and in medicine generally.

Also, the committee recommended that the KSMA notify voluntary health groups that it has a committee which was set up to work in this general area, and that it is available to lend its assistance and cooperation in this field.

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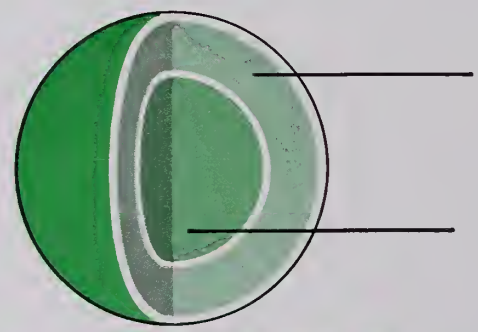
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Hyoscyamine sulfate	0.0518 mg.
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Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

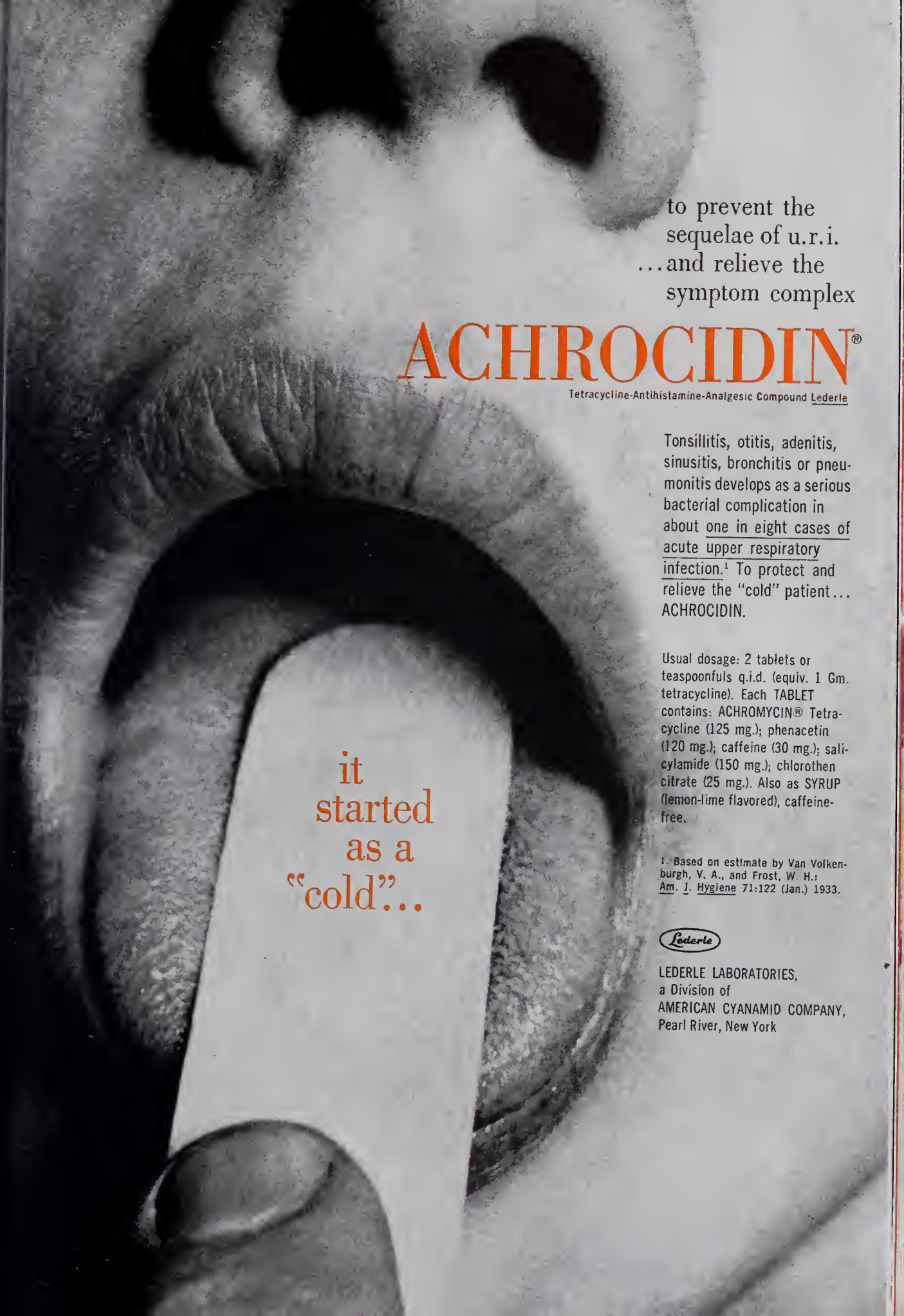
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Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP (lemon-lime flavored), caffeine-free.

1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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Pertinent Paragraphs

"Digest of Prepaid Dental Care Plans, 1958," containing descriptions of nearly 100 group dental care plans, has been prepared by the Division of Dental Resources of the Public Health Service. Covering all known plans in the U. S., the 46-page digest is designed to assist professional and lay groups interested in organizing prepayment programs. Single copies are available on request from the Division of Dental Resources, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

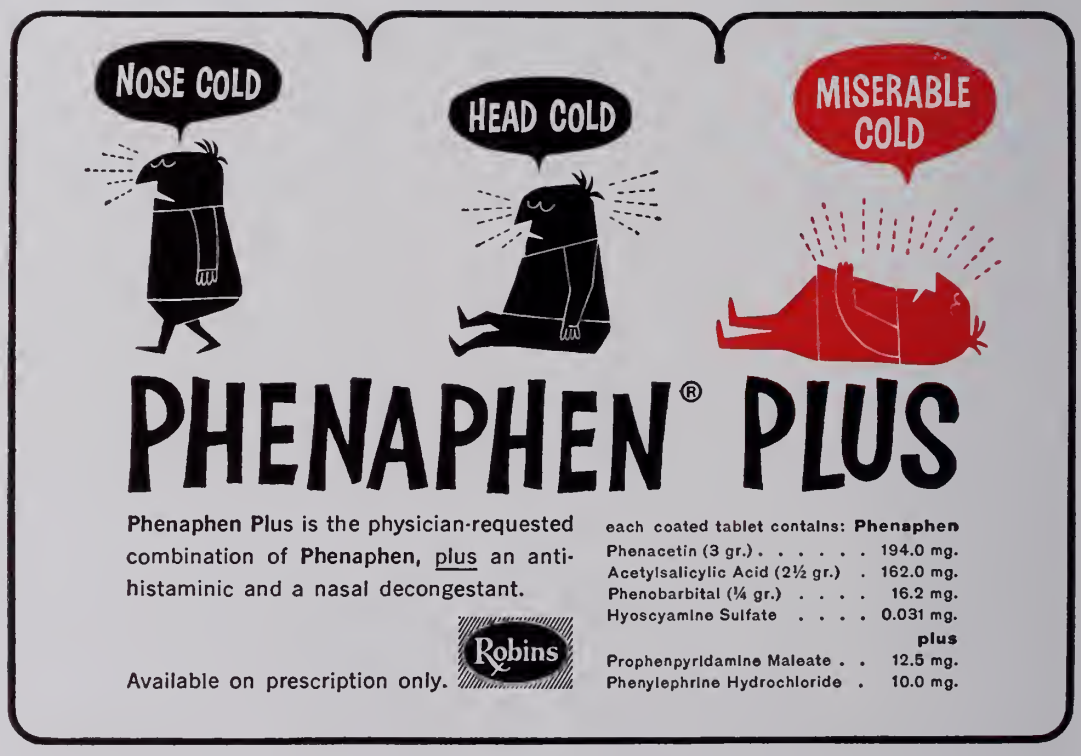
An essay on the "Advantages of the American Free Enterprise System" by Carol Pryor of Elizabeth, New Jersey, won the top prize of $1,000 in the national contest sponsored by the Association of American Physicians and Surgeons, Inc. Kentucky's entry in the national contest was an essay by Carole Siebert, Covington, who won the state-wide contest.

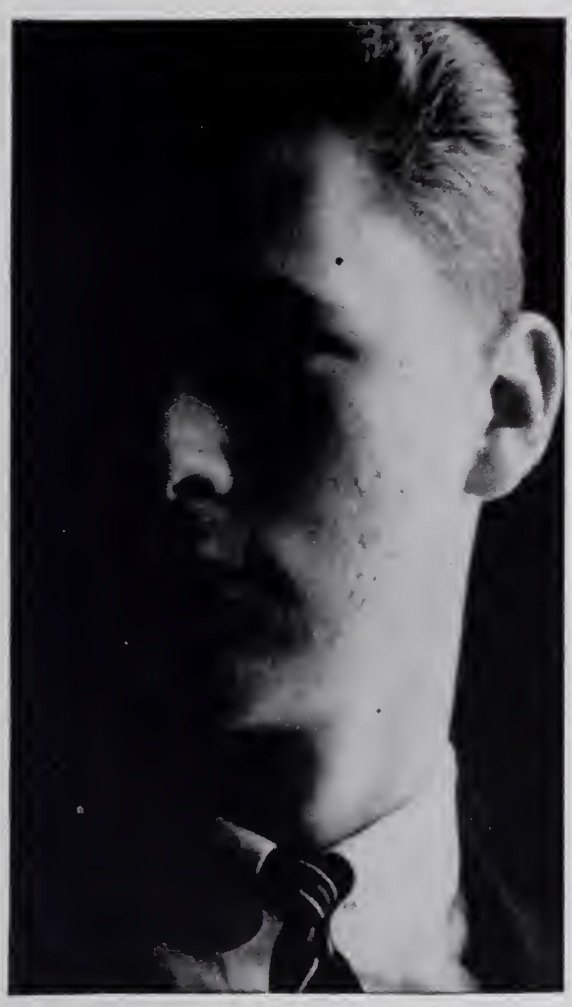
The Committee for Economic Development predicted recently that by 1975 the average income of American families, after payment of all taxes, should be at least $7,100. This is compared with the present average disposable income of $5,300 per family. "Achievement of this high average income is not an imagined utopia, it is a practical goal for practical men," the Committee said. It is the result of a study by a subcommittee of businessmen and economists.

A "Symposium on Evaluation of Early Diagnosis of Cancer" will be presented at the annual Scientific Session of the American Cancer Society on October 26-27 at the Biltmore Hotel, New York City, N. Y. The program is fully approved and recommended by the American Academy of General Practice for 12 hours of Category II credit for its members.

A minimum of 505 Health Scholarships to help provide four years of college or university education in career preparation for five of the key professions will be offered starting in 1959 by the National Foundation. Formerly the National Foundation for Infantile Paralysis, Inc., the Fund will offer scholarships in medicine, nursing, physical and occupational therapy, and medical social work. Purpose of the Scholarship is to help alleviate the national shortage of professional health personnel. For further information consult the counselor or dean of the school you are attending or write to Health Scholarships, 800 Second Avenue, New York 17, N. Y.

Admissions to schools of professional and practical nursing reached a new high in 1958, according to the Committee on Careers, National League for Nursing, New York. An estimated 46,600 students entered basic professional nursing schools, compared with 44,281 the preceding year. Some 20,000 began training for careers in practical nursing, compared with 16,710 the year earlier.





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1. Hodges, F.T.: GP 14:86, Nov., 1956.

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE # 40: This patient was a 19-year-old married white girl who had an acute episode of sudden lower abdominal suprapubic pain while she was washing some clothes April 16, 1958. This was described as so severe it caused her to double up and feel faint.

Her husband brought her to the private physician's office and she complained of severe pain in her lower pelvic region. She looked very pale and anemic and was "frightened." She had no vaginal bleeding.

Significant past history: She had a spontaneous abortion some three months before and was hospitalized and transfused a total of three pints of blood at that time. Since then her menstrual periods had been fairly regular, but she had been spotting intermittently for the last 2-3 weeks. She had no nausea nor any breast changes suggestive of pregnancy. On admission to the hospital, 4-16-58, her blood pressure was 114/75, temperature 98.6. She was a poorly nourished, anemic looking white girl complaining of pain over the pelvis and the right lower abdomen. She said this pain also radiated posteriorly in the upper chest as well as up and down her spine.

Physical examination revealed the abdomen soft except over the fundus of the uterus where it was very tender. Some pain and tenderness was also present in both adenexal regions. Pelvic examination revealed no vaginal bleeding. The uterus didn't seem enlarged. No masses could be palpated.

Laboratory work: RBC 3,774,000-73%, 11 grams hemoglobin, hematocrite 34
initial count WBC 8,450-92% polys
count repeated 3,552,000 10 grams hemoglobin, hematocrite 32
catherized urinalysis—normal.

The admitting impression was possible early appendicitis, possible early ectopic pregnancy. A frog test was ordered and it was positive.

The patient was then taken to the operating room and a cul de sac puncture was done. No free blood was obtained so a D & C was planned.

At this time her blood pressure was 120/74, pulse 90 and she seemed apprehensive. She was examined under pentothal anesthesia. The outlet was parous with fair support, the cervix seemed somewhat eroded and had a slight cyanotic color. The uterus was not enlarged, it was in anterior position and was easily palpable. There were no masses in either adnexia.

The cervix was dilated with a Goodell dilator and a sponge forcepts was passed exploring the corpus. A moderate amount of mebrane and cystic looking material was obtained. The anesthestist then informed the surgeon the patient was pulseless and five seconds later she ceased breathing. Her chest was ausculated and no heart beat could be heard. It was felt cardiac arrest had taken place so the chest was opened within one minute, going through the sixth interspace on the left. The heart was found beating very feebly and rapidly. An ankle cut down was attempted since the peripheral veins were collapsed and a vena puncture was not possible. She received 500 cc dextran i. v. as rapidly as possible and 500 cc whole blood. This was all that was compatable in cross matching in the hospital. A cut down was done on the other ankle and 1000 cc 5% G/S with terramycin and 2 ampules of levophed added.

The chest was closed during the above and an underwater drain was inserted with suction. The lung was kept expanded by the anesthetist during the procedure. A very faint pulse then became perceptible and her blood pressure ranged between 30-55. The patient's general condition remained very precarious in spite of pumping the blood in as rapidly as it could be obtained. Her blood pressure never rose above 55 mg and frequently faded back. Aspiration of the abdomen was attempted to see if blood could be obtained. The tap was negative. In spite of giving 1500 cc of whole blood and 500 cc dextran and double strength levophed within a period of one and a half hours the patient gradually faded. Her

(Continued on page 1122)

Acosta-Sison, M.D., from the University of the Philippines reported 243 chorionic malignancies studied from 1928 to 1956 in *Obstetrics and Gynecology,* 10:165-1957. Since they see many more of these tumors than we do in the States there seems some justification for reviewing some of their current theories as to etiology. Is this the result of a maternal environmental defect, most likely a nutritional one that may result in the development of these lesions? Another possibility is some disturbance which prevents the woman from mobilizing her defenses against the invasive trophoblastic tissue.

Until recently this tumor was one of the most highly malignant, and resulted in ultimate death. There now exists an apparent specific therapy for chorionepithelioma with the drug methotrexate, an aminopterin derivative. Four patients have been reported as cured by Li and Hertz (in press).

Until this can be properly evaluated early diagnosis and treatment of hydatidiform mole are essential. Of the highest diagnostic significance is the presence of a positive biological test for pregnancy on the patient's urine, patricularly in a dilution of 1/50 or higher, with a rising titer.

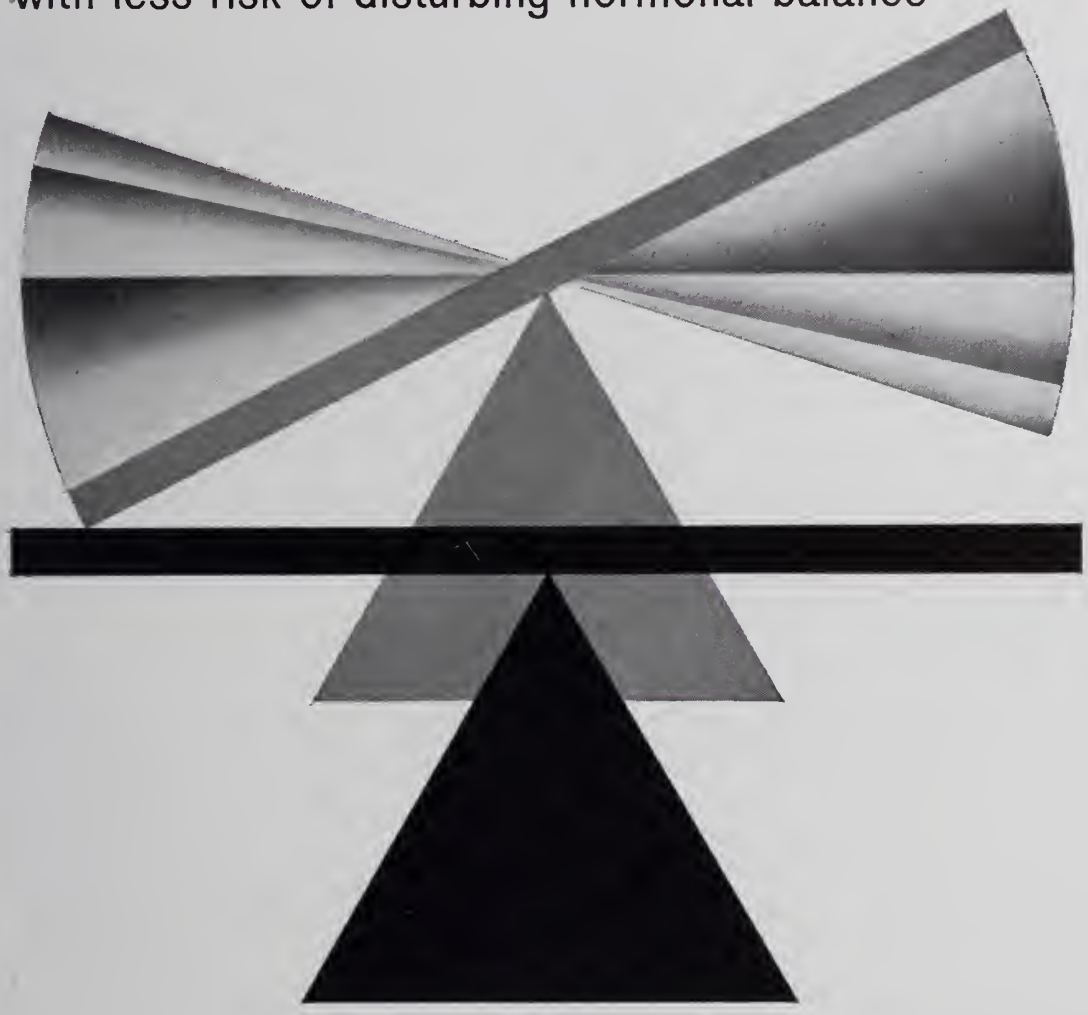
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

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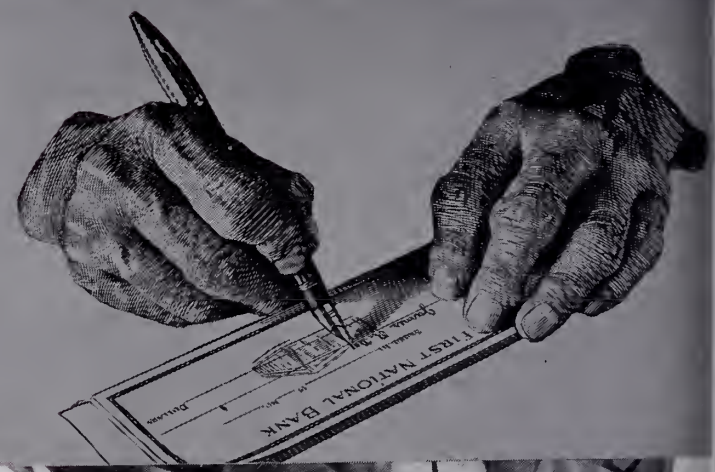
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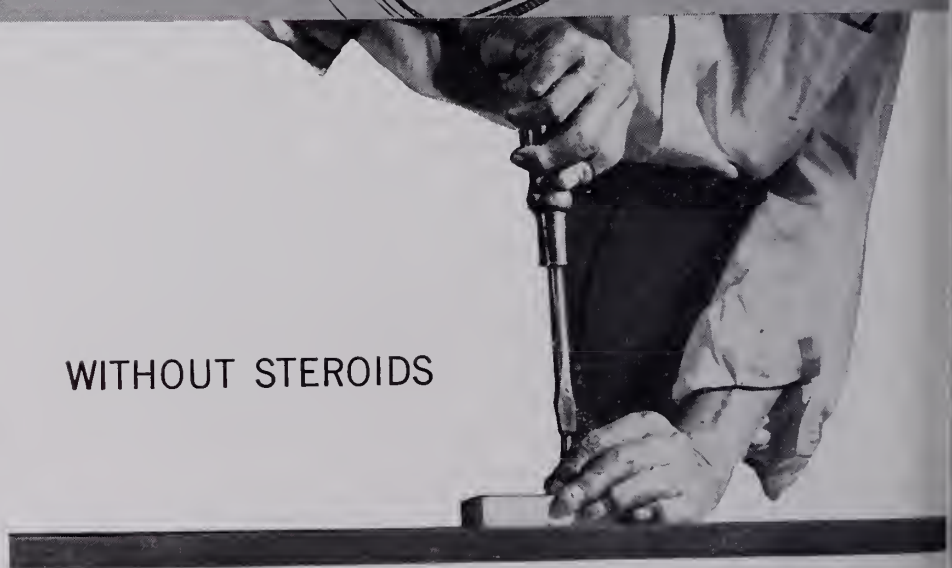


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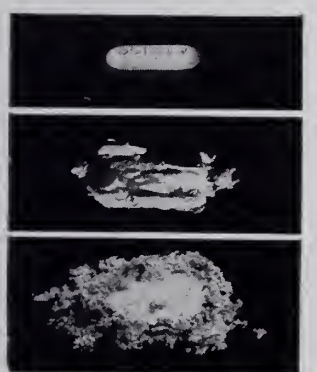
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Dosage: Two or three tablets 3 or 4 times daily.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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THE PLASMA PROTEINS Clinical Significance: by Paul G. Weil, M.D., Ph.D.; published by J. B. Lippincott Company, Philadelphia, February, 1959; 133 pages; price, $3.50.

This text by Doctor Weil is intended to be one of the "Practitioner's Pocket Books" published by Lippincott and the material contained in the text was published in the *American Practitioner and Digest of Treatment for September, 1958.*

The author has attempted to present the plasma proteins in light of their extreme importance to life itself and illustrates this point. A well known biologic fact that coacervate complexes were the beginning of genesis and now through new modes of investigation the discovery of hypertensinogen, abnormal hemoglobins, etc., is used in Doctor Weil's illustration.

It has long been established that without proteins life itself would not exist, yet the true importance is emphasized and new intense interest stimulated by the development of newer techniques of study such as electrophoretic method, ultracentrifugal method, physiochemical method, combined method, and the immunologic method.

Doctor Weil's mission seems to be the introduction of the practicing physician to these methods and their contribution to the study of normal and abnormal tissue and plasma proteins and their consequent relationship to the clinical aspect of disease.

More specifically, the electrophoretic method and ultracentrifugation have provided us with the ability to detect abnormal globulins in disease states such as myelomatosis, collagen disease, macroglobulinemia, and its close associate cryoglobulinemia—as well as globulin deficient states, such as hypo and agammaglobulinemia.

Other globulin fractions of extreme clinical importance relative to life threatening disease are mentioned superficially; namely fibrinogen and fibrinolysin. The existence of the syndrome of free bleeding and uncontrollable hemorrhage due to afibrinogenemia and its amelioration with fibrinogen transfusions as well as the counterpart fibrinolysin transfusion (plasmin) with its ability to lyse intramuscular thrombi is of extreme recent interest.

It should be pointed out at this time that the entire text deals with essentials and therefore merely acquaints the practitioner with the existence of plasma protein fractions and their relationship to disease. An extensive bibliography for more extended reading is adequately provided.

Further methods for finer fractionation of globulins may eventually answer many unanswered questions as to the etiology of abnormal protein disease (proteinoses), diseases of the reticuloendothelial systems as well as collagen diseases and allied inflammatory auto-immune reactions and possibly neoplastic diseases.

Reemphasis is made to the fact that the well known liver function tests, which are often keenly depended upon to make a diagnosis of hepatocellular inflammation, are in reality dependent upon changes in plasma proteins. Cephalin cholesterol flocculation, colloidal gold, Takata ARA Test and zinc sulphate are all dependent upon an increase in gamma globulin and the thymol turbidity test is dependent upon an increase in beta globulin.

A discussion of the protein nature of plasma proteins is not complete without pointing out the relationship of tissue protein to plasma protein, as the author illustrates by the differentiating serologic reactions, such as L. E. test in disseminated lupus erythematosis and the Sensitized Sheep Cell or Latex Flocculation reaction in rheumatoid arthritis.

A short treatise such as this is extremely difficult to compose on such a technical yet important subject. The contents, however, do express the author's wide knowledge of his material, but require the reader to use the bibliography for the addtion of substantial information.

Harold C. Morris, M.D.

THERAPEUTIC RADIOLOGY: by William T. Moss, M.D., published by C. V. Mosby Company, St. Louis, 1959; 403 pages; price, $12.50.

The author of this small volume on the subject of radiation therapy has a unique and eminently practical work to his credit. It is unique in that a detailed discussion of the effects of radiation upon normal tissues precedes each section. The pathologist will use this as an invaluable source of information on such effects. It will serve as his reference book on this subject.

The eminent practicality of the book will be immediately apparent to the radiologist. The indications, contraindications, and limitations are evaluated for both supervoltage and conventional voltage radiotherapy. The results to be expected from most carefully planned and executed treatment techniques are described. The details of the techniques are set down in simple straightforward language.

The otolaryngologist, gynecologist and surgeon will appreciate the factual and unbiased appraisal of radiation therapy for cancers of different organs. The merits of radiotherapy versus surgery are discussed simply and dipassionately. A long experience in clinical radiotherapy makes the author's opinions valid.

(Continued on page 1116)



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In the Books

(Continued from page 1114)

The clinician will find them trustworthy.

The complications of radiotherapy are carefully and completely described. The discussion of radiation effects on normal tissues is aimed at the avoidance of over-irradiation as well as under-irradiation. Reduction in the numbers of complications can be expected.

While this book deals largely with the treatment of malignant tumors some attention is given to benign tumors and related conditions. The subject of benign lesions is covered with considerable detail with regard to bone tumors. The treatment of inflammatory conditions is outlined, but with limited discussion.

The radiation therapist can do no less than recommend this book to those practitioners of medicine who deal with cancer.

Gerald M. Peterson, M.D.

GENERAL UROLOGY: by Donald R. Smith, M.D.; published by Lange Medical Publications, Los Altos, Calif.; second edition; 1959; 328 pages; price, $4.50.

This text has been designed primarily for the medical student and those with special interests in urology. The lithography is excellent although the print is somewhat small. A modified outline form is followed throughout, with each entity discussed in a brief concise manner, and accompanied by numerous well done reproductions.

Due to the outline presentation, the small print and the absence of excess verbiage a surprising amount of information is contained within the 321 pages.

All the usual subjects are covered as well as the addition of four chapters discussing Intersexuality, Renal Hypertension, Infertility and Psychosomatic Urologic Syndromes. The chapter on Urologic Laboratory Examination would be valuable reading for any young Physician. This is an excellent basic text.

John J. Robbins, M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

ANESTHESIA FOR INFANTS AND CHILDREN: by Robert M. Smith, M.D., published by C. V. Mosby Company, St. Louis.

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY: by Isadore Meschan, M.D., Published by W. B. Saunders Company, Philadelphia and London.

PREVENTIVE MEDICINE: by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D.; published by W. B. Saunders Company, Philadelphia and London.

TEXTBOOK OF PEDIATRICS: edited by Waldo E. Nelson, M.D.; published by W. B. Saunders Company, Philadelphia and London.



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PUBLIC HEALTH PAGE

The Importance Of Fungus Infection Of The Lungs In Tuberculosis Control

RUSSELL E. TEAGUE, MD.

Commissioner of Health
Commonwealth of Kentucky

SEVERAL pathological conditions, such as carcinoma or fungus infections, affecting the lungs, either primarily or secondarily, may simulate tuberculosis. The most common systemic fungus infections affecting the lungs are histoplasmosis, blastomycosis, and coccidioidomycosis.

Histoplasmosis is caused by the fungus, Histoplasma Capsulatum. The organism grows in the soil, particularly in humid areas, and is often found in abundance in soils contaminated with bird droppings. It is endemic in the Ohio and Mississippi River valleys, and for that reason is often called Valley River. All age groups may be affected, from young infants through older adults. The disease frequently manifests itself as an infection of the reticuloendothelial system, resulting in enlargment of the lymphnodes, liver and spleen. However, most commonly the fungus is inhaled, setting up primary infection in the lungs, which may closely resemble and is frequently misdiagnosed as tuberculosis. It is not spread from person to person or from animals to man. Usually the infection is mild, presenting clinical symptoms like "flu." X-Rays taken during the first few months of the disease show numerous small soft areas of infiltration, 2 to 3 mm. in size. After 3 to 4 years these areas become calcified and simulate the calcification seen in primary or miliary tuberculosis.

Because of X-Ray resemblance to tuberculosis, patients with active histoplasmosis are often diagnosed as having tuberculosis, in spite of a negative Tuberculin Test and repeated sputum cultures negative for acid fast organism. If the sputums are consistently negative for tubercle baccilli, a diligent search should be made elsewhere for the diagnosis. The Histoplasma Capsulatum organism can often be isolated from sputum collected in bottles containing a special antibiotic solution. The importance of repeated collection of sputum specimens for both acid fast and fungus studies and the necessity of testing for both Tuberculin and Histoplasmin skin sensitivity as a differential diagnostic procedure cannot be too strongly emphasized.

In Kentucky, because of widespread fungus growth, many persons will react to Tuberculin and Histoplasmin. In such instances where neither acid fast bicilli or Histoplasma Capsulatum have been isolated from the sputum or gastric washings, a complement fixation test may be helpful in establishing the diagnosis. This serological test is positive only during the active stage of the disease but when complement fixing antibody is present in a titre 1:8 to 1:16 (depending on the laboratory standards) or when a rise in titre is demonstrated, the diagnosis is virtually assured.

It is well to keep in mind that the effort spent in arriving at an accurate diagnosis will ultimately save the physician, nurse, and patient much time and trouble. Until recently acute systemic cases of Histoplasmosis were highly fatal. In 1957, a fungicide—Amphotericin B (Fungazone—Squibb) was shown to be very effective in these cases. This drug has considerable toxicity, must be given intravenously, usually for a period of 4 to 6 weeks under close supervision, and for this reason it is customarily reserved for systemic infections and those cases of pulmonary histoplasmosis with cavitary disease. As previously stated, the majority of cases will heal spontaneously. In moderately severe infections where healing occurs slowly, the patient experiences a long period of lethargy, anorexia, and other symptoms characteristic of this chronic form of the disease. In most instances this will clear eventually without residual effects.

Blastomycosis, caused by Blastomyces dermatitidis, may manifest itself as a slowly evolving chronic infection of the skin, *as a subacute suppurative infection of the lungs*, or as a generalized systemic infection which may involve any or all organs of the body.

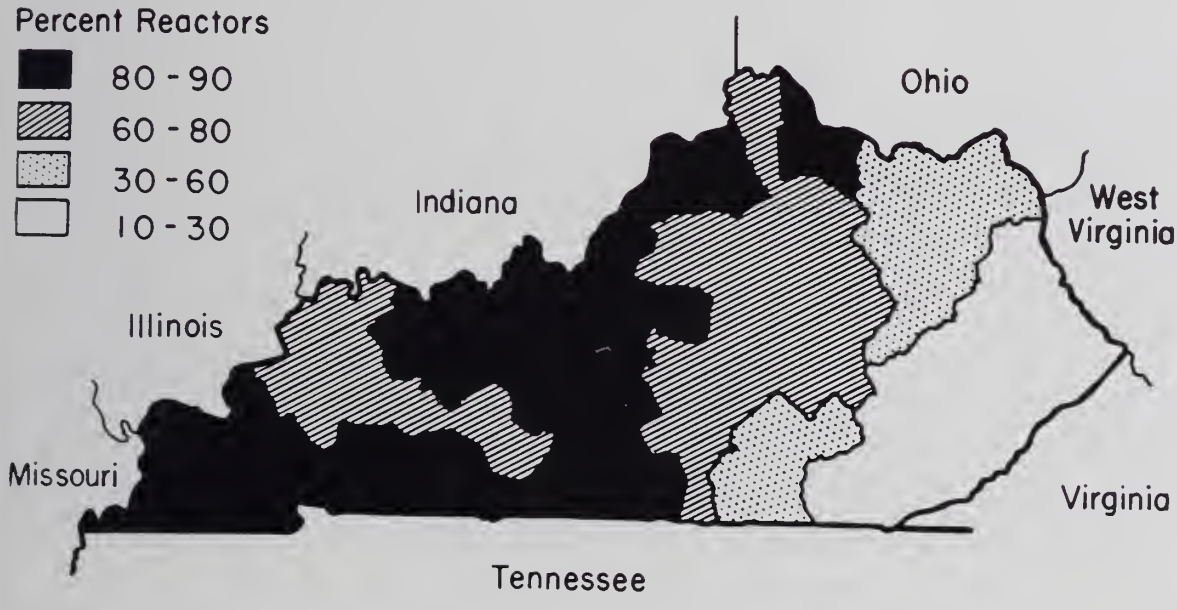
The most common clinical form is cutaneous. Pulmonary Blastomycosis usually begins as isolated pneu-

monic lesions in any part of the lung, apparently as a result of inhalation of the organisms. As with Histoplasmosis, it is frequently misdiagnosed as carcinoma or tuberculosis. Occasionally the organism may invade the chest wall and produce multiple draining sinuses. It occurs most commonly between the ages of 20 and 40; males are affected 9 times as frequently as females.

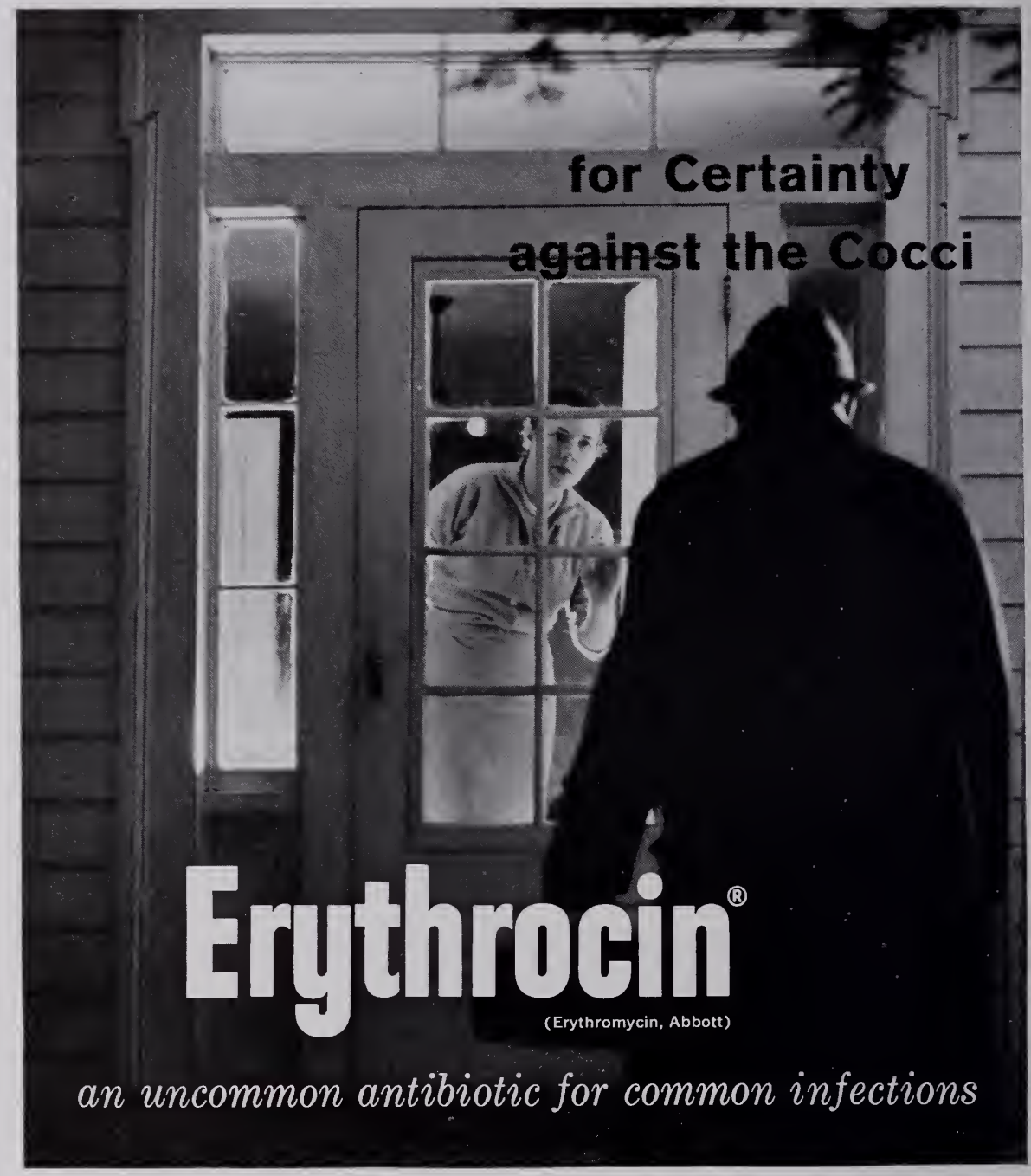
Epidemiological studies of Blastomycosis, comparable to those of Histoplasmosis, have not been made. As yet we do not know how or where the fungus grows or the actual method of transmission. Since we are concerned primarily with differentiating Blastomycosis from Tuberculosis and Histoplasmosis, the same diagnostic measures apply. A skin test material is available although the usefulness of blastomycin is diminished by virtue of a cross reaction with Histoplasmin. Serological tests similar to those for Histoplasmosis are available, and the fungus may be demonstrated in the sputum if active pulmonary lesions are present. However, interpretation of serological reactions as well as the most effective methods for culturing the organism have not been adequately worked out.

Coccidioidomycosis: a dust-borne infection caused by Coccidioides immitis. Two forms are known: (1) primary, usually an acute benign self-limiting respiratory infection, and (2) a progressive, chronic malignant and disseminated form. This disease is limited geographically to the southwestern United States, and is highly endemic in the San Joaquin valley of California.

It is of interest here because, on X-Ray, it produces cavitary lesions similar to those seen in tuberculosis. A history, of having lived in the southwestern United States, may provide a clue to the diagnosis of Coccidioidomycosis in persons where lesions resembling those seen in tuberculosis are present but diagnosis of tuberculosis can not be proved.



Histoplasmin Sensitivity in Kentucky



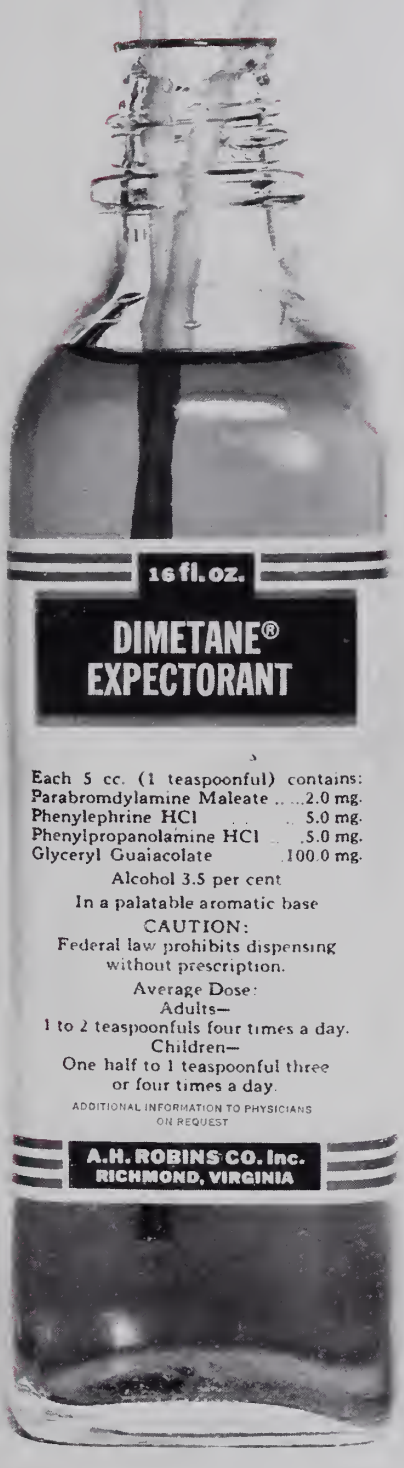
Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs® (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.

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MARGARET KELLY, R. N., Director of Nurses

Maternal Mortality

(Continued from page 1110)

pulse became completely imperceptible in the last half hour and her blood pressure was unobtainable. She expired in the operating room.

Autopsy was obtained. The significant findings revealed approximately 5000 cc of blood in the peritoneal cavity. The uterus weighed 285 grams and measured 11.5 cm from the cervical os to the fundus. The source of bleeding was an irregular perforation of the uterus extending down behind the left broad ligament. When the uterus was opened there was found some more shaggy tissue clinging to the fundus. This hemorrhagic necrotic tissue penetrated through the entire thickness of the uterus at this point.

The gross diagnosis was malignant hydatidiform mole. Death from exsanguination. Microscopic diagnosis: malignant hydatidiform mole, chorio adenoma destruens. No other remarkable pathological alteration except some pulmonary edema.

Comment

The Committee felt this case was most unusual and clearly demonstrated the importance of the autopsy. By the AMA definition this must be classified as a direct obstetrical death since she had been pregnant three months previously and aborted.

Special Article

(Continued from page 1073)

insurance industry in meeting the problems of health care for the aged. This is as it should be —it is the American way. This is the economical and effective way. This is the method that preserves the dignity of the individual, the integrity of the community—it is the way that has made the United States the great country it is. This should be destroyed if HR 4700 is enacted.

Gentlemen, you have been very kind to let us present this testimony to give you reasons why we, in the Kentucky State Medical Association, feel HR 4700 should not be reported favorably.

May we close our statement by urging you to remember that this problem has always been handled at the local and state levels. There is every reason to believe that it is still the problem of the individual, his family, the community, religious groups and local political subdivisions, working with the various private purveyors of insurance coverage to solve—in the American Way.



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
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Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

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1. Pennington, V. M.: Meprobamate (Miltown) in premenstrual tension. J.A.M.A. **164**:638, June 8, 1957.

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l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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Alcohol	.75%

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BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

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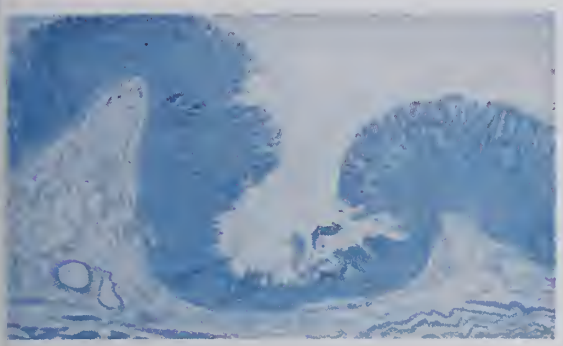
Regular aspirin crystals 24 hours after being mixed into water.



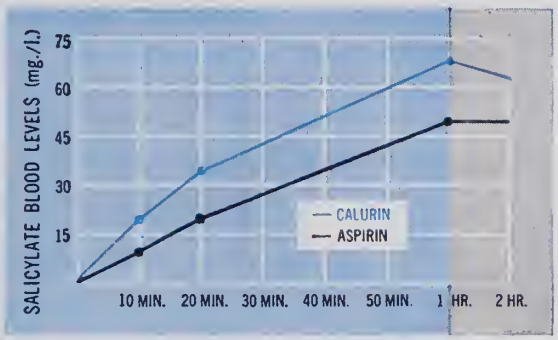
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Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

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3. Sodium-free — for safer long-term therapy.
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Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

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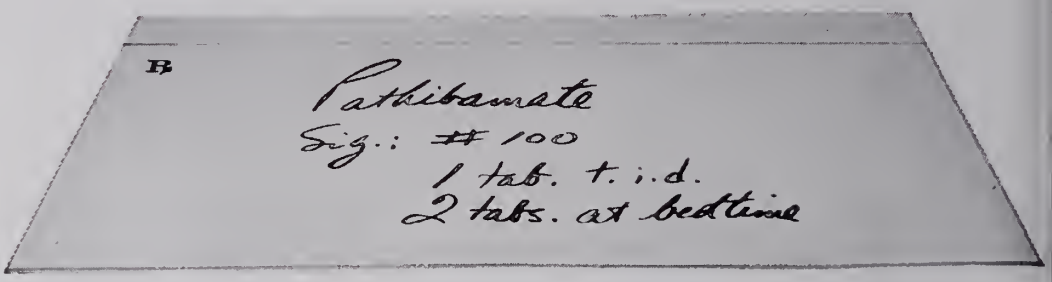
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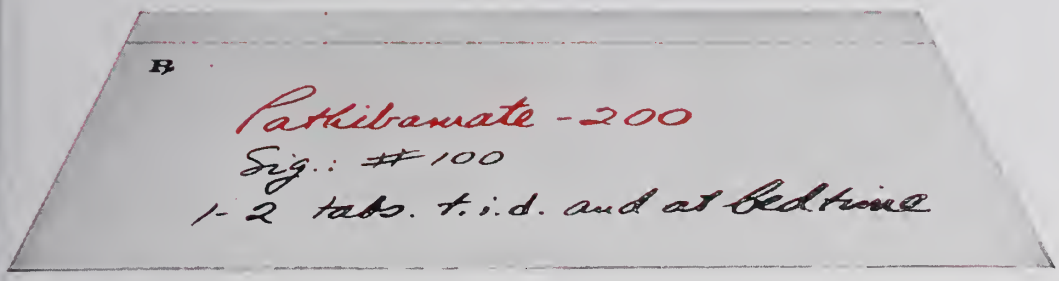


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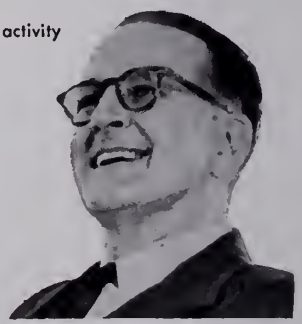
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Dormethan (brand of dextromethorphan HBr)	30 mg.
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APAP (N-acetyl-p-aminophenol)	325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

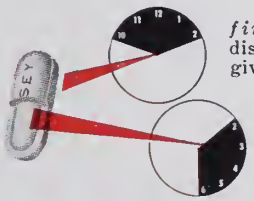
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George P. Archer, Prestonsburg (Alternate)	1960

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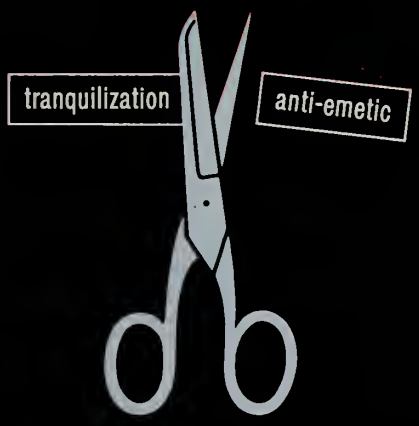
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Twelfth District	Garnett J. Sweeney, Liberty	1959
Thirteenth District	Charles B. Johnson, Russell	1961
Fourteenth District	Charles C. Rutledge, Hazard	1959
Fifteenth District	Keith P. Smith, Corbin	1960

BUYERS GUIDE

Journal of the Kentucky State Medical Association, September, 1959

Abbott Laboratories 1018-1120
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Ayerst Laboratories 1031
Blue Cross Hospital Plan 1131
Brayten Pharmaceutical Co. 1098
Burroughs Welcome Company 1037
Central Pharmaceutical Co. INSERT-1029-1030
City View Sanitarium 1137
Coca-Cola Company 1116
Crocker-Fels Company 1109
C. K. Cundiff 1104
Endo Laboratories 1115
Foundation Hospital 1105
Geigy Pharmaceutical Co. 1111
Glenbrook Labs. (Bayer Aspirin) 1033
Highland Hospital 1032
Lederle Laboratories 1032-1035-1040-1074-1075-1104-1107-1109-1125-1132-1133
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Physicians Casualty 1040
Purdue Frederick Co. 1028-1138
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J. B. Roerig Co. 1022-1023-1099-1126
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Smith-Dorsey & Co. 1019-1024-1025-1112-1113-1128-1129-1139
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Wallace Laboratories 1089-1135
B. R. Whipple 1105
Winthrop Laboratories INSERT-1091-1092-1093-1094
Winthrop Laboratories 1019-1038-1039-1109-1117-1136

now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action – divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis—even when given in quantities far in excess of the usual dosage.

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."[5]

NO JAUNDICE

"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."[6]



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY "... produced extremely satisfactory results in the broad therapeutic range represented in this series."[3]

POTENT AGENT "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."[4]

MAJOR ADDITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent.... It is effective in a variety of psychiatric disorders, including schizophrenic reactions.... The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."[6]

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."[7]

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life ... were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."[8]

"... extremely satisfactory results ..." in a clinical spectrum ranging from minor nervous disorders to severe psychotic disturbances[3]

RESULTS WITH MELLARIL IN 194 PATIENTS[3]

ACUTE PSYCHOTICS	CHRONIC PSYCHOTICS	NEUROTICS
83% satisfactory effect	68% satisfactory effect	57% satisfactory effect
Some cases had complete remission of symptoms. Most were able to return home to useful occupations	Relief of symptoms in cases permitted easier management and a return to a more or less useful life	Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

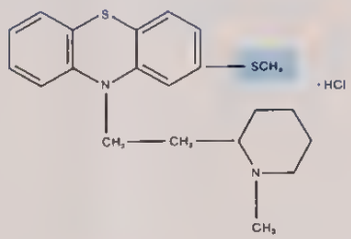
RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS[3]

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25



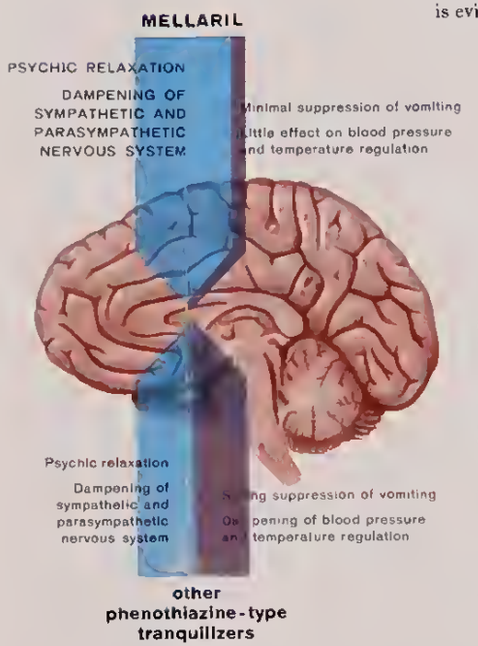


a new advance in tranquilization:
greater specificity of tranquilizing action plus fewer side effects



Of 109 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical (S·CH$_3$) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



other phenothiazine-type tranquilizers



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD — where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE — where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE — in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1. Ostfeld, A. M.: Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J.: Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-21, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959.

- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

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THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels

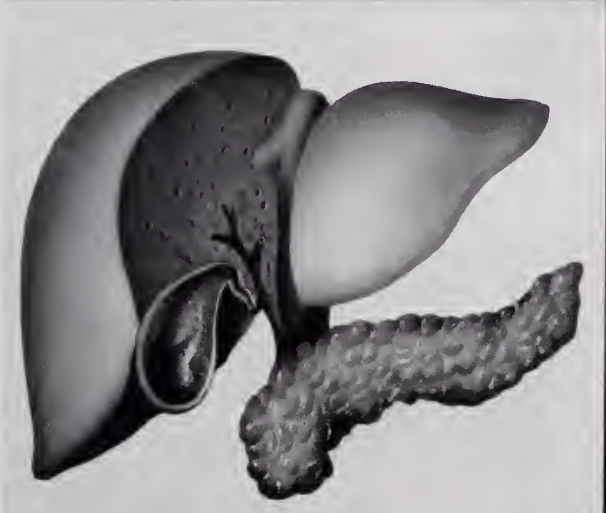


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CLINICAL BRIEFS FOR MODERN PRACTICE



why should the urine be tested for sugar in acute cholecystitis?

The high incidence of pancreatic disease associated with pathologic conditions of the biliary tract indicates their close relationship. The appearance of glycosuria in acute cholecystitis points to involvement of the pancreas in the inflammatory process.

Source: Refresher Article: Biliary Tract Diseases, M. Times *85*:1081, 1957.

to help forewarn of pancreatic involvement...
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"...the most satisfactory method for home and office routine testing...."
GP *16*:121 (Aug.) 1957.

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for prompt and sustained relief from
severe mental and

emotional stress



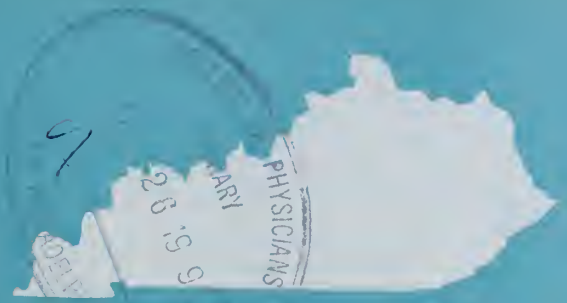
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DIABETES
DETECTION
WEEK
NOV. 15-21



PHYSICIANS

The JOURNAL of the Kentucky State Medical Association

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KENTUCKY STATE MEDICAL ASSOCIATION
ORGANIZED 1851

OCTOBER 1959 · VOLUME 57 · NUMBER 10

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN



IN EPILEPSY... PREREQUISITE FOR PARTICIPATION: THERAPY

With the use of medications, epileptic students may be enabled to participate in many of the same activities as other students.[1]

REQUISITE FOR THERAPY: THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

effective anticonvulsants for most clinical needs

for control of grand mal and psychomotor seizures

Dilantin® KAPSEALS® "In the last 15 years several new anticonvulsant agents have come into clinical use but they have not replaced diphenylhydantoin [DILANTIN] as the most effective single agent for a variety of reasons. Most of them are less effective in control of seizures, have a greater sedative effect and higher incidence of sensitivity reactions."[2]

A drug of choice for control of grand mal and psychomotor seizures, DILANTIN sodium (diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals of 0.03 Gm. and 0.1 Gm. supplied in bottles of 100 and 1,000.

Phelantin® KAPSEALS When it has been demonstrated that the combination of Dilantin and phenobarbital is helpful in a patient and that these drugs are well tolerated, the use of PHELANTIN, a capsule providing both drugs, is often a great morale builder because it enables the physician to reduce the total number of pills or capsules the patient is required to take. It is less expensive medication and it prevents the patient from manipulating the dosage.[3] PHELANTIN also contains methamphetamine (desoxyephedrine) to minimize the sedative effect of phenobarbital.

PHELANTIN Kapseals (Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.) are available in bottles of 100.

for the petit mal triad

Milontin® KAPSEALS • SUSPENSION MILONTIN is one of the most effective agents for the treatment of petit mal epilepsy. Relatively free from untoward side effects, MILONTIN successfully reduces both the number and severity of petit mal attacks without increasing the frequency or severity of grand mal attacks in those patients with combined petit mal and grand mal epilepsy. Also, MILONTIN is considered an excellent choice for initiating therapy in untreated patients.[4-6]

MILONTIN Kapseals (phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000. Suspension, 250 mg. per 4 cc., 16-ounce bottles.

Celontin® KAPSEALS CELONTIN is effective in the treatment of petit mal and psychomotor epilepsy. It provides effective control with a minimum of side effects, frequently checks seizures in patients refractory to other anticonvulsant medications, and does not tend to precipitate grand mal attacks in those patients with combined petit mal and grand mal seizures. For this reason, CELONTIN is useful in treating patients with more than one type of seizure and can be given in combination with Dilantin.[7-10]

CELONTIN Kapseals (methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.

bibliography: (1) Green, J. R., & Steelman, H. F.: Epileptic Seizures, Boltimore, Williams & Wilkins Company, 1956, p. 136. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Davidson, D. T., Jr., in Conn, H. F.: Current Theropy 1959, Philodelphia, W. B. Sounders Company, 1959, p. 512. (4) Smith, B., & Forster, F. M.: *Neurology* **4**:137, 1954. (5) Zimmerman, F. T.: *New York J. Med.* **55**:2338, 1955. (6) Lemere, F.: *Northwest Med.* **53**:482, 1954. (7) Perlstein, M. A.: *Pediat.. Clin. North Americo*: **4**:1079 (Nav.) 1957. (8) Livingstan, S., & Pouli, L.: *Pediatrics* **19**:614, 1957. (9) Corter, C. H., & Moley, M. C.: *Neurology* **7**:483, 1957. (10) Keith, H. M., & Rushton J. G.: *Proc. Staff Meet. Moya Clin.* **33**:105, 1958.

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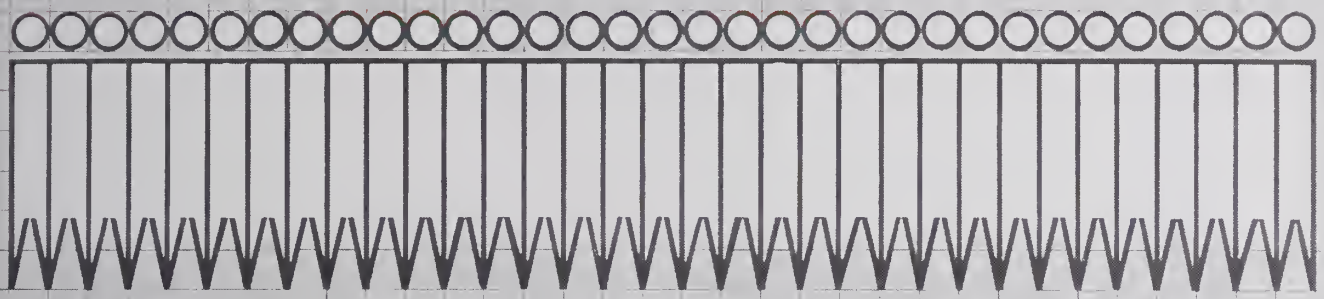
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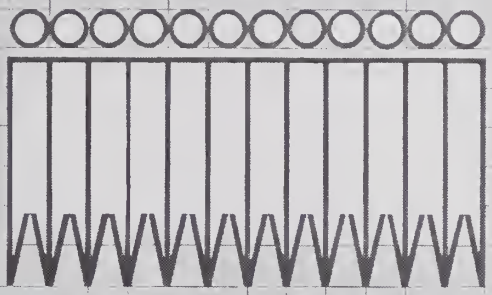
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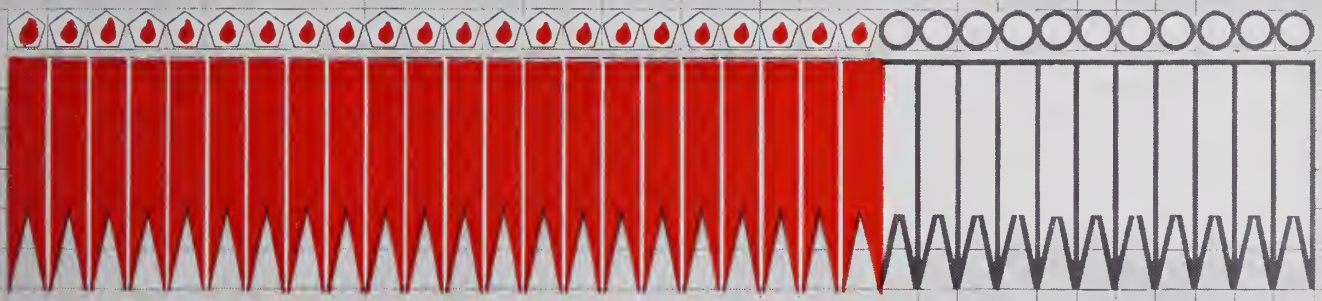
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who were refractory
to other corticosteroids*





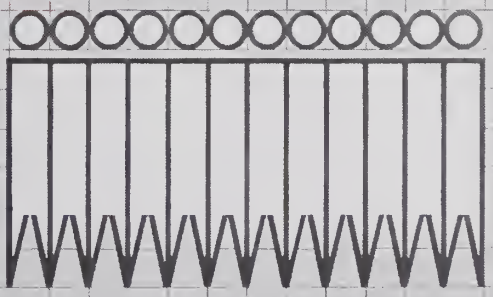
22 were successfully
treated with **Decadron**[1,2]

1. Boland, E. W., and Headley, N. E.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.
2. Bunim, J. J., et al.: Paper read before the Am. Rheum. Assoc., San Francisco, Calif., June 21, 1958.

*Cortisone, prednisone and prednisolone.

DECADRON is a trademark of Merck & Co., Inc.

Additional information on DECADRON is available to physicians on request.



MSD Merck Sharp & Dohme
DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

JUST ONE TABLET DAILY





provides therapeutic sulfa levels for 24 hours... Highly soluble in acid and alkaline media... rapidly absorbed, producing fast, effective plasma-tissue concentrations sustained for the entire day. Simple, single 0.5 Gm. daily dose minimizes patient dosage confusion. At least equivalent to 4 to 6 Gms. daily of previous sulfonamides. Does not produce renal complications.[1]

with low incidence of sensitivity reactions... KYNEX is extremely low in toxic potential.[2,3] Cutaneous or other objective sensitivity reactions are rare, as demonstrated in a large scale evaluation of clinical toxicity.[2] Also minor subjective reactions are less likely to develop when the recommended dosage is used.[2]

Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first-day dose of 1 Gm. (2 tablets).

TABLETS, 0.5 Gm., Bottles of 24 and 100.

also available—KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz.

1. Editorial, New England J. Med. 258:48, 1958.
2. Vinnicombe, J.: Antibiotic Med & Clin. Ther. 5:474, 1958.
3. Sheth, U. K., et al.: Ibid., p. 604, 1958.

for improved control

WHENEVER SULFAS ARE INDICATED

KYNEX®

Sulfamethoxypyridazine Lederle

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



MESSAGE FROM THE PRESIDENT

A Priceless Heritage

In this country, every citizen is guaranteed by the Constitution freedom of thought, action, worship, assembly, and independence. The fear of secret arrest and condemnation without a public trial is unthinkable. The Writ of Habeas Corpus is a practical reality. Every citizen is, however, equally bound by the Laws of this Land which are created by Congress in Washington.

In certain Eastern countries the government is autocratically controlled and directed by a small group of men who are allegedly elevated to office by a single, small party, representing less than 3.5 per cent of the ruling country's population. In this country, every citizen of legal age possesses the inherited, priceless privilege of voting, without fear of retaliation, for any individual who is voluntarily seeking any and every office.

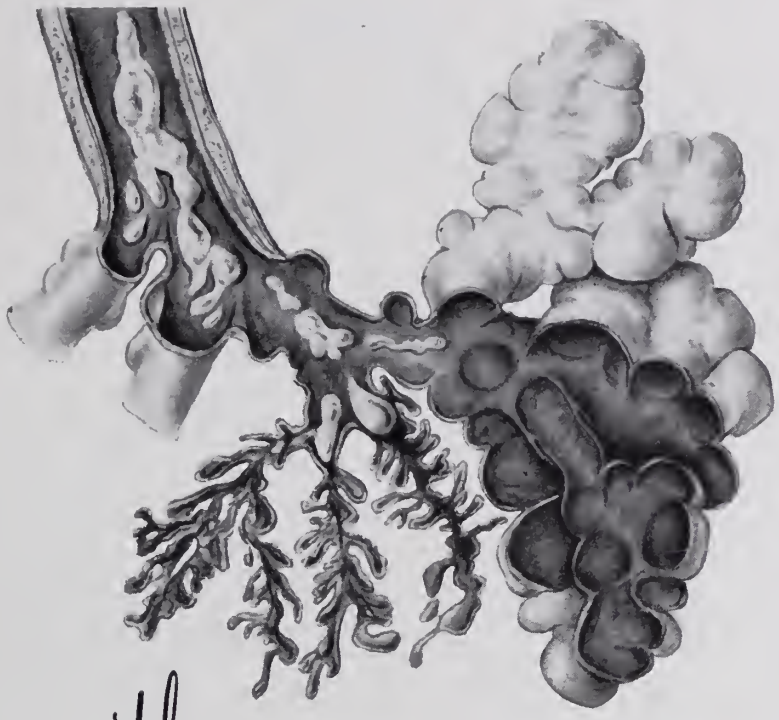
As of August 20, 1959, 13,322 bills were introduced into the 86th Congress. Of these, 475 were either medical bills or embodied medical relations. The Congressmen are fully informed day after day by the proponents of these bills. While they welcome and even solicit the views of all the people, they are primarily and factually interested in the views of those people who elected them to office. These views can only reach them through the communications media of private conversation and private letter.

No one dreamed last November, or even last June, that anything but the mildest labor legislation, if indeed any at all, would emerge from Congress, for Congress is controlled by men friendly to unions, many of whom are deeply indebted to unions. The arrogance of certain labor leaders, the insulting threat of retaliation at the polls, and the President's public appeal were admittedly factors. However, the private conversations and the private letters of the voters of this country made it politically inexpedient for the individual Congressman to act otherwise.

The future of medicine can be planned and even directed by the medical profession. The final mold will inevitably be fashioned by Congress which creates the Laws that govern this Country.

Through communications much is possible. Through default all can be lost.

Louis Ahlee Jr.



Clear the air

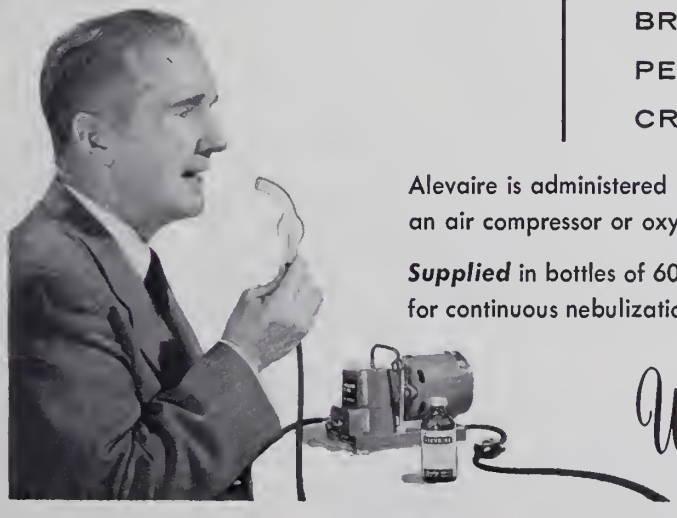
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WETS, THINS, LOOSENS PULMONARY SECRETIONS

Very useful in...

... BRONCHITIS
BRONCHIAL ASTHMA
BRONCHIECTASIS
PERTUSSIS
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Alevaire is administered by means of a nebulizer operated with an air compressor or oxygen.

Supplied in bottles of 60 cc. for intermittent and 500 cc. for continuous nebulization.

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If she needs nutritional support . . . she deserves

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For Quality without Question... Enjoy the unique refreshment of sparkling Coca-Cola



SIGN OF GOOD TASTE



for the acute asthmatic attack

rapid control by the oral route
without fear of g.i. intolerance

ELIXIR SYNOPHYLATE®

(Theophylline Sodium Glycinate)

the *buffered* theophylline that permits adequate oral xanthine dosage...better absorbed and better tolerated than aminophylline...formulated to provide effective blood levels in just 15 minutes

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) theophylline sodium glycinate, equiv. 0.16 Gm. (2½ gr.) Theophylline U.S.P.; 20% alcohol.

Dosage: Adults—2 tablespoonfuls t.i.d. Children—2 to 3 teaspoonfuls if over 12 years; 1 to 2 teaspoonfuls if 6-12 years; 1 teaspoonful if 3-6 years; ½ to 1 teaspoonful if 1-3 years. May be repeated after 8 hours.

Bottles of 1 pint, 1 gallon.

THE CENTRAL PHARMACAL COMPANY
Products Born of Continuous Research
Seymour, Indiana

...and for routine management **SYNATE TABLETS**

for subacute
and chronic
asthma
...pulmonary
emphysema
and bronchiectasis

comprehensive
symptomatic control
by the oral route
without fear of
g.i. intolerance

SYNATE
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TABLETS

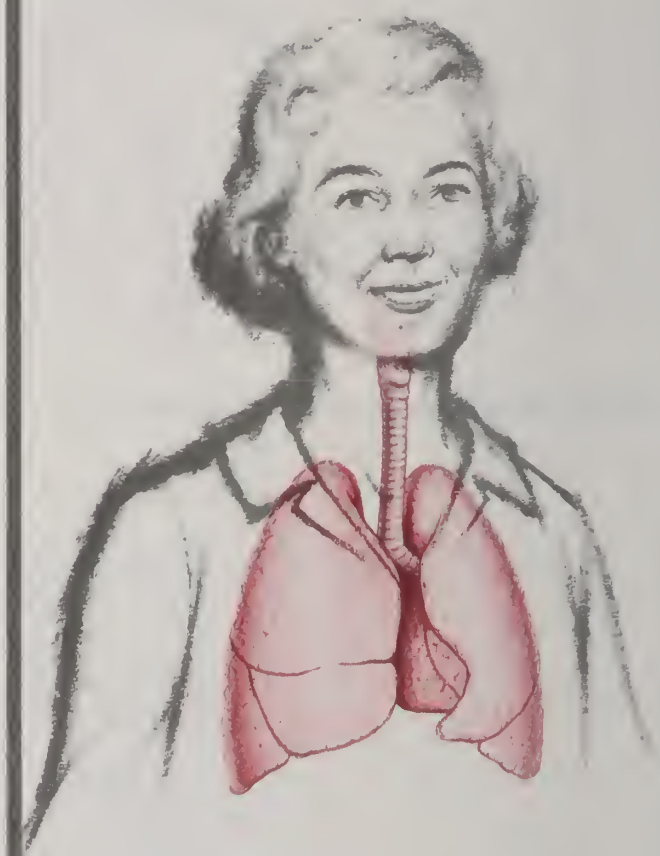
the optimally effective, well-tolerated oral xanthine[1-3]—theophylline sodium glycinate—in a comprehensive formulation for full symptomatic control... keeps patient comfortable and reduces incidence and severity of acute attacks • in emphysema due to allergic asthma or chronic infectious bronchitis, it provides rapid bronchial dilatation, as well as decongestant and expectorant benefits

Each SYNATE Tablet contains:

Theophylline Sodium Glycinate (SYNOPHYLATE®)	360 mg.
Racephedrine Hydrochloride	30 mg.
Potassium Iodide	300 mg.
Secobarbital (Warning: May be habit-forming)	20 mg.
Niacinamide	40 mg.

Dosage: One tablet q.i.d. with water.
Bottles of 100, 500.

1. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 2. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.



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...and for the acute attack
ELIXIR SYNOPHYLATE



the disease of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is "one of the most widespread and serious protozoan diseases of man," yet "there is no parasite more often misdiagnosed than is *E. histolytica*." Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

new Glarubin

TABLETS

specific for intestinal amebiasis

THE S. E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

NEW YORK • KANSAS CITY • SAN FRANCISCO



THE INSURANCE PAGE



Can Voluntary Insurance Do The Job?

FOR the time being, HR 4700 (the Forand Bill) appears to be dormant, since it did not get out of the House Ways and Means Committee at this last session. It would be a grave mistake for those who oppose the type of legislation involved in this bill, i.e., "free" hospital care for the recipients of Social Security benefits, to assume that the idea has been abandoned. It can still be brought out of Committee and it is almost certain that an attempt will be made at the next session of Congress to pass the Forand bill, or similar legislation.

One of the principal arguments advanced by the proponents of HR 4700 was the allegation that the Blue Shield plans and the private commercial insurance carriers cannot provide adequate coverage on a prepaid insurance basis, to pay for the necessary health care for our senior citizens, at premium rates which most of them can afford.

In the hearings on HR 4700 a few weeks ago, before the Ways and Means Committee of the House of Representatives, Leonard Larson, M.D., Chairman of the Board of Trustees of the American Medical Association, reported on the progress which had been made under the present system of health care in this country. He stated that the ultimate solution to the problems of health care for the aged can be found in private and voluntary care at the community level, and in private health insurance, (which includes both commercial and Blue plans).

In 1945, Dr. Larson stated, less than one American out of three had voluntary health insurance. Today, the figure is nearly three out of four.

This indicates that prepayment plans, by providing expanded health coverage for all age groups, are anticipating tomorrow's problems for health care financing of the aged.

In December, 1958, the AMA House of Delegates adopted a proposal which applied specifically to those over 65 with modest resources and low family income. This proposal urged physicians to set their fees at a level which will encourage the continued development of insurance and prepayment plans at reduced premiums. In regard to the progress which is being made along these lines, Dr. Larson reported to the Ways and Means Committee that there were 25 plans in 23 states offering Blue Shield programs for those over 65, and that in 16 other states, the Medical Societies, in cooperation with the plans which they sponsor, were developing programs of a similar nature.

According to the Health Insurance Association of America, sixty percent of our senior citizens *who need and want* health insurance, will have protection by the end of next year; seventy-five percent will be covered by 1965; and ninety percent by 1970.

These are indeed optimistic and impressive estimates. If the American public, and more especially, our legislators in Washington can be convinced that such estimates will be realized, it is probable that our government will permit the voluntary health care plans to develop and to improve their coverage; and that government will not take over this task. On the other hand, if our voluntary health plans cannot or do not continue to provide broader and more complete coverage for this segment of our population, it is almost certain that increasing pressure from labor leaders and others will cause Congress to enact legislation to provide health care for our older people at government expense.

To put it bluntly, the future of our system of medical practice is at stake in this issue. Every state and county medical society, and all physicians individually, must do all within their power to see that the voluntary prepayment plans are sucessful and that they are acceptable to the groups for whom they were designed.

It has become apparent that there are some in our ranks who are lukewarm or even hostile toward the idea that we should offer a special program of prepaid insurance at reduced fees and lowered premium rates to those of our senior citizens who have liimted resources and income. Whatever their motives —whether from a feeling of defeatism, or because of a lack of understanding of the issues involved, such physicians are of course entitled to their viewpoint.

One fact should be self evident, however. If voluntary insurance does not make it possible for our older people to provide the necessary health care for themselves, then there will exist a large vacuum into which compulsory health care, on a national level, will move. Such a step in all probability, would be the beginning of the end, as far as our present system of medical practice is concerned.

Can voluntary insurance do the job? It not only *can—it must!*

W. Vinson Pierce, M.D.

Now—All cold symptoms can be controlled



Tussagesic

timed-release *tablets*

Controls congestion

with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever

with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

TRIAMINIC® .....50 mg.
(phenylpropanolamine HCl .....25 mg.
pheniramine maleate .....12.5 mg.
pyrilamine maleate .....12.5 mg.)
Dormethan
(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate .....180 mg.
APAP (N-acetyl-p-aminophenol) .....325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

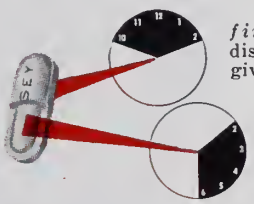
Controls cough centrally

with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus

with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

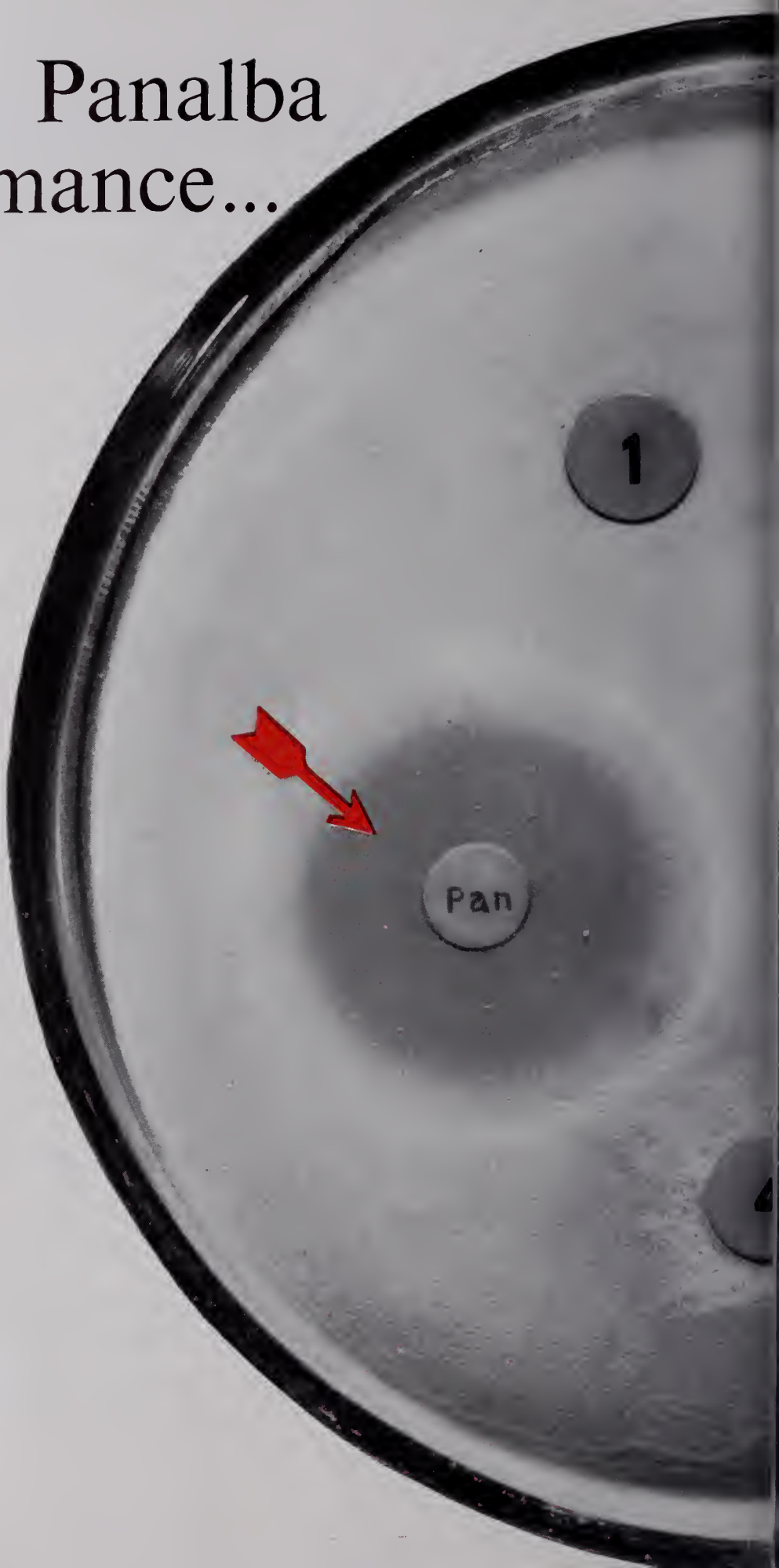
then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

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in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription :

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

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The broad-spectrum antibiotic of *first* resort



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whenever there is inflammation, swelling, pain

VARIDASE®

STREPTOKINASE-STREPTODORNASE LEDERLE

BUCCAL *Tablets*

conditions for a fast comeback...

as in acute hemorrhoids...

SUNDAY, 9 A.M.: VARIDASE for painful thrombotic hemorrhoid. 2:30 P.M.: pain greatly reduced, less swelling and inflammation.

MONDAY: size down to small tab; acute inflammation disappeared.*

VARIDASE activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement; swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster... in trauma or infection.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.
Supplied: Boxes of 24 and 100 tablets

*Peterman, R. A.: Clinical report cited with permission.

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vaginal
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physiologically
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ethically promoted

Meta Cine®

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Meta Cine represents a carefully designed formula which provides the physician with a vaginal douche preparation which safely and effectively maintains a clean healthy vagina.

Meta Cine is a combination of several ingredients clinically established as valuable in promoting proper vaginal hygiene. Diluted for use, Meta Cine possesses the desired pH (3.5); contains the mucus digestant, papain, which dissolves mucus plugs and coagulum; contains lactose to promote growth of desirable döderlein bacilli, and methyl salicylate for soothing stimulation of circulation within the vaginal walls.

Its pleasant, deodorizing fragrance also meets the esthetic demands of your patients.

Meta Cine is promoted exclusively to the medical profession, and recommends itself as your preparation of choice for patients who might otherwise indulge in unsupervised self-medication with potentially damaging nonphysiologic douches.

Supplied in 8-oz. containers, and boxes of 30 individual-dose packettes. Two teaspoonfuls, or contents of one packette, in 2 quarts of warm water, douche as prescribed.

Printed douching instructions for patients available upon request





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. . . and one to grow on

A tiny tablet of REDISOL to stimulate the appetite — to help in the intake of food for growth.

REDISOL is crystalline vitamin B_{12}, an essential vitamin for growth and the fundamental metabolic processes.

Ideal for the growing child, the REDISOL tablet dissolves instantly on contact in the mouth, on food or in liquids.

Packaged in bottles hermetically sealed to keep the moisture out and to retain vitamin potency in 25 and 50 mcg. strengths, bottles of 36 and 100 — in 100 mcg. strength, bottles of 36, and in 250 mcg. strength, vials of 12.

Also available as a pleasant-tasting cherry-flavored elixir (5 mcg. per 5-cc. teaspoonful) and as REDISOL injectable, cyanocobalamin injection USP (30 and 100 mcg. per cc., 10-cc. vials and 1000 mcg. per cc. in 1, 5 and 10-cc. vials).

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for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
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Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*–400 mg. *unmarked,* coated tablets.

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NOW

. . . a new way to relieve pain and stiffness in muscles and joints

indicated in:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

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LOW BACK PAIN

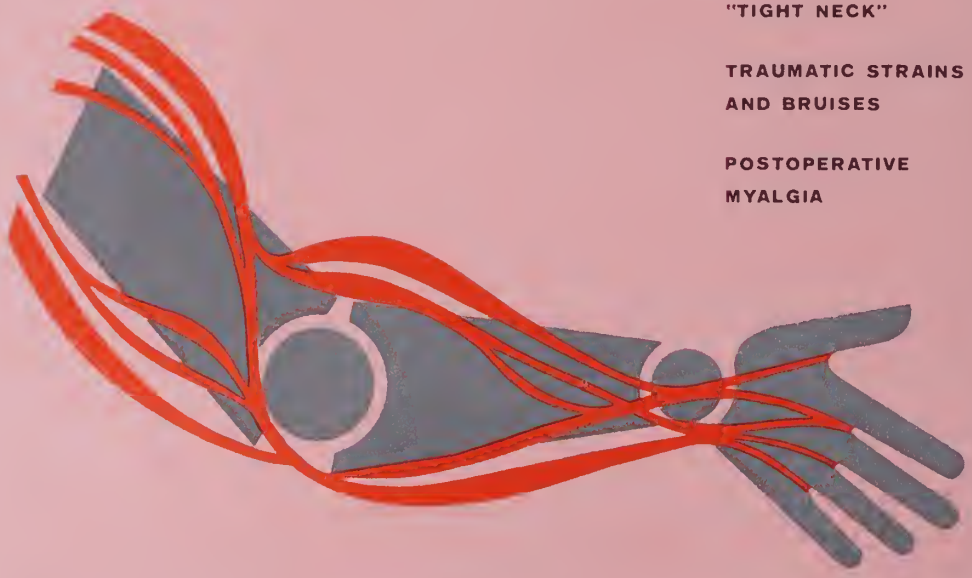
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"TIGHT NECK"

TRAUMATIC STRAINS AND BRUISES

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■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

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SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.

Literature and samples on request.

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A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders. The Hospital is located in a 75-acre tract, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and emotional rehabilitation. The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

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he deserves

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NO SALT ..*but seasoned*



A meal of even the most colorful and the most meticulously prepared food can be dreary eating without salt. Neocurtasal, for the patient on a low-sodium diet, brings back flavor to foods—makes eating a pleasure once more.

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An excellent salt replacement
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Contains potassium chloride, potassium glutamate, glutamic acid, calcium silicate, potassium iodide (0.01%).

2 oz. shakers and
8 oz. bottles

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Assures patient's cooperation

relieve the tension—and control its G.I. sequelae



...Pathibamate®

meprobamate with PATHILON® tridihexethyl chloride Lederle

for relieving tension and curbing hypermotility and excessive secretion in G. I. disorders

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.)—a tranquilizer and muscle-relaxant widely accepted for the effective management of tension and anxiety

PATHILON (25 mg.)—an anticholinergic long noted for producing prompt symptomatic relief through peripheral, atropine-like action, yet with few side effects

now available...

PATHIBAMATE-200 Tablets

200 mg. meprobamate • 25 mg. PATHILON

for more flexible control of G. I. trauma and tension smooth, sugar-coated, easy-to-swallow

PATHIBAMATE-400 and PATHIBAMATE-200 are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Supplied: PATHIBAMATE-400—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

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WASHINGTON NEWS DIGEST



Washington D. C.—Congress this year failed to take final action on any legislation of major interest to the medical profession except for the annual appropriation for medical research.

However, work was started on three measures of particular concern to physicians—the Forand, Keogh-Simpson and international health research bills. Showdown votes on them are probable next year. If there are not votes next year, they will die and must be reintroduced in 1961 if they are to be considered further by Congress.

The House Ways and Means Committee held hearings on the Forand bill, but deferred showdown voting on it until next year. The legislation—which is vigorously opposed by the medical profession, other groups on the health team and the Eisenhower Administration—would provide hospital, surgical and nursing home care for federal Social Security beneficiaries. Social Security taxes would be raised to help finance the expensive program.

The Keogh-Simpson bill, after being approved by the House, was left hanging in the Senate Finance Committee. The Senate committee held two sets of hearings. It could vote early next year on the legislation which would grant income tax deferrals to physicians and other self-employed persons as an incentive to invest in private pension plans.

Chairman Oren Harris (D., Ark.) postponed until next session a vote by the House Commerce Committee on the Senate-approved international medical research bill because of a backlog of more urgent measures requiring committee action this year. He said that "a diligent effort" would be made during the recess to clarify a number of points at issue revealed in testimony before his committee.

The bill calls for an annual $50 million authorization to finance a new national institute of health to foster international medical research programs and cooperation. The Administration opposes some of its provisions.

President Eisenhower and Arthur S. Flemming, Secretary of Health, Education and Welfare, made clear that they didn't feel bound to spend the additional $106 million which Congress voted for medical research. Congress raised the $294 million requested by the President to $400 million.

Mr. Eisenhower expressed concern that Congress is going too fast in providing medical research funds which are adminstered by the National Institutes of Health. He warned of a danger that the quality of research projects might be lowered and that manpower and other resources might be diverted from "equally vital teaching and medical practice."

He directed that every project approved must be "of such great promise that its deferment would be likely to delay progress in medical discovery."

Secretary Flemming said that the President's criteria would be followed conscientiously. But the Secretary gave assurance that the restrictions would not be so rigid as to hamper research by denying funds for worthwhile projects.

One of the most important and surprising developments during this session of Congress was the political power shown by Mr. Eisenhower, a lameduck Republican president, in generally calling the shots on legislation although Democrats controlled the House and Senate with substantial majorities.

In his fight against "big spending" measures sponsored by Democrats, the President effectively used his veto power to get the bills more to his liking. The Democrats were unable to muster the votes to override vetoes of two housing bills.

A third compromise housing bill retained three provisions of interest to the medical profession. One would provide Federal Housing Administration loan guarantees for building proprietary nursing homes. A second would provide FHA loan guarantees and direct loans for housing for elderly persons. The third would authorize loans for construction of housing for interns and nurses.

Live polio vaccine may be licensed for public use within a year or two, Leroy E. Burney, M.D., Surgeon General of the Public Health Service, said:

"If energetic efforts are continued to find answers to the remaining technical questions concerning safety, effectiveness and manufacturing procedures, one or more of the three vaccines now being proposed may be under production within one to two years."

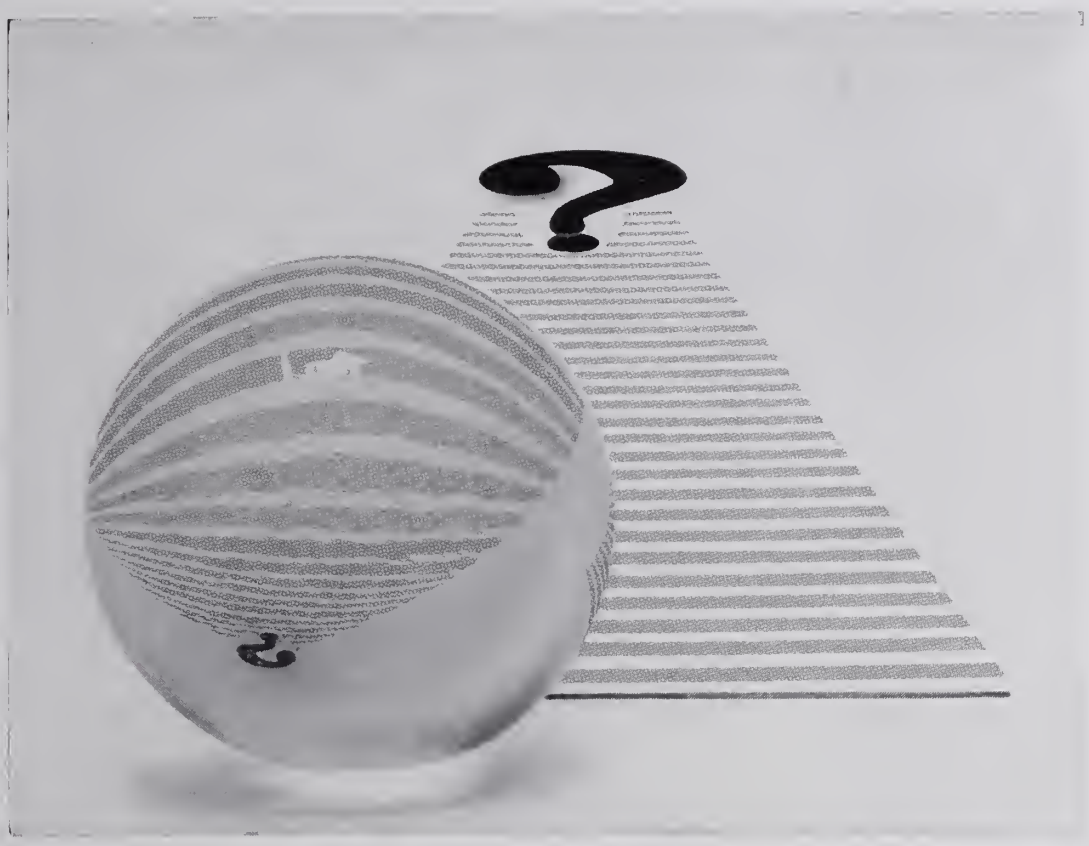
Primary responsibilty for radiation health safety has been transferred from the Atomic Energy Commission to the Department of Health, Education and Welfare.

Such a shift in responsibility was called for in legislation pending in Congress but President Eisenhower ordered the transfer without Congressional action.

The President directed HEW to "intensify its radiological health efforts and have primary responsibility ... for the collation, analysis and interpretation of data on environmental radiation levels such as natural background, radiography, medical and industrial uses of isotopes and X-rays and fall-out."

HEW Secretary Flemming also was named chairman of a cabinet-level Federal Radiation Council.

Officers in charge of the Medicare program for military dependents were optimistic that certain medical benefits dropped for economy reasons in October, 1958, will be restored next January 1. But the professional director of the program, Col. Norman E. Peatfield, said that the Medicare permit system will be retained.



what lurks beyond the broad spectrum?

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References: 1. Dowling, H. F.: Postgrad. Med. *23*:594 (June) 1958. 2. Gimble, A. I.; Shea, J. G., and Katz, S.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1958, p. 876. 3. Long, P. H., In Kneeland, Y., Jr., and Wortis, S. B.: Bull. New York Acad. Med. *33*:552 (Aug.) 1957. 4. Rein, C. R.; Lewis, L. A., and Dick, L. A.: Antibiotic Med. & Clin. Ther. *4*:771 (Dec.) 1957. 5. Stone, M. L., and Mersheimer, W. L.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia Inc., 1956, p. 862. 6. Campbell, E. A.; Prigot, A., and Dorsey, G. M.: Antibiotic Med. & Clin. Ther. *4*:817 (Dec.) 1957. 7. Chamberlain, C.; Burros, H. M., and Borromeo, V.: Antibiotic Med. & Clin. Ther. *5*:521 (Aug.) 1958. 8. From, P., and Alll, J. H.: Antibiotic Med. & Clin. Ther. *5*:639 (Nov.) 1958.

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1. Collective Study, Department of Medical Research, Winthrop Laboratories.
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1. J.A.M.A., *170*:184 (May 9), 1959.

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Further Observations on Cholecystectomy*

J. DUFFY HANCOCK, B.S., M.D., F.A.C.S.

Louisville, Ky.

IN 1952 I presented a paper on the "Complications of Biliary Tract Surgery." This was based upon a review of approximately 300 cases operated upon in the preceding seven years. During the intervening seven years three-hundred odd more cases have been treated. It is hoped that the contrast and comparison of the two series may be of some interest and engender some discussion and suggestions for improving the management of future cases. No attempt will be made to report an exhaustive statistical study.

While a higher percentage (over two-thirds) of the cases in the second series showed demonstrable stones before surgery, many were operated upon without this specific indication. I still feel that clinical symptoms form an entirely justifiable basis for surgery. In those cases in which the complaints are largely of gaseous indigestion, variable pain, and intolerance to fats, the diagnosis can be quite difficult and may have to be based largely upon exclusion. It is in this group of patients that the highest percentage of unsatisfactory results are obtained. However, in a fairly adequate follow-up I do not recall any patients made worse and a very definite number relieved. Operative findings in this latter group have included stones overlooked by the roentgenologists—and they do miss some—cholesterosis, post-inflammatory adhesions, pancreatic disease and kinked or narrow cystic ducts. In brief, one should have the courage to advise surgery in the absence of demonstrable stones if other explanations for the symptoms are inadequate. An appreciable salvage of uncomfortable patients will be accomplished.

Read before the Kentucky Surgical Society 1959 Annual Meeting at French Lick Springs Hotel, French Lick, Indiana.

Mortality and Complications

My mortality in this second series was higher than that in the first, and I rather think that all of us will probably face a similar situation in the future. We are operating upon an older, less vigorous age group, malignancy is more common and with increasing hospitalization benefits that type of case is more likely to stay in the hospital until the end and technically add to operative mortality statistics. The nine cases (constituting a mortality under three per cent) included three malignancies, all of whom could have been discharged earlier from the hospital, two cases of diagnosed cirrhosis who were operated upon because of disabling colic and with no expectation of a permanent cure, one coronary, one uremia, possibly secondary to blood transfusions, one pulmonary edema in a patient devitalized by long pre-operative infection and one frail 79-year-old patient who failed to survive the operative trauma.

Practically no change in operative technique was instituted in this second series of cases. The

same motto of eternal vigilance was employed —and with increased dividends. There were no technical complications in the second group of cases whereas in the first there were two—a cystic artery that finally required the retention of clamps post-operatively and a damaged common duct thought to be a continuation of an acutely angled cystic duct. If one is patient such difficulties can usually be avoided by insisting upon clear visualization of the structures. In large or distended gallbladders the maneuver, popularized by Dr. Lahey, of freeing the gallbladder from above downward and retracting it toward the patient's left has been found useful in more and more cases. However, when employed it does commit the surgeon to a cholecystectomy.

Observations on Technique

While any one of a number of incisions may be employed, I still use the oblique right subcostal. It gives good access to the stomach and common duct as well as the gallbladder. It can be continued downwards for adequate exposure of the appendix. It is easy to close, and I believe is less uncomfortable during the immediate post-operative period.

In this second series I again found the individual ligation of the cystic artery and duct most satisfactory. It is an automatic insurance feature. The junction of the cystic and common ducts is necessarily exposed in separating the duct from the artery, and the presence of accessory blood vessels is likely to be demonstrated. Mass ligation of the two structures has been done successfully thousands of times by competent men but I still believe it is the more hazardous method for the average surgeon.

With care cholecystectomy, which is the desired procedure, can be accomplished in practically every instance. In over 300 cases the gallbladder was removed in all but nine. In one instance, the gallbladder had been previously removed, in three it was anastomosed with the jejunum, and in another it was utilized for drainage when pancreatitis was present. In other words, there were only four instances where it was felt it was unsafe to remove the gallbladder. When this condition exists no apology is needed for adopting the safer procedure of cholecystostomy if the cystic duct and artery cannot be visualized.

In spite of the fact that I have heard indirectly that one of my patients has been operated upon elsewhere for a long cystic duct with included stone, I still follow those who feel that it is a mistake to ligate the cystic too close to the common duct. One should always be able to palpate the duct for the presence of a stone which can then be milked back into the gallbladder or removed through a small incision. Should symptoms arise later from the unduly long segment of cystic duct or should stone formation occur in it one will find it much easier and safer to remove some excessive cystic duct that it is to repair a damaged common duct where recurrent obstruction is common and crippling. Ligating the stump before cutting it will give one a second look and an opportunity for revision if indicated. Should the stump be so short that a ligature might tent the common duct, a small French catheter can be introduced through the opening into the common duct. There will be rather profuse drainage for a few days as through a T tube in choledochostomy, but the tract will gradually close.

Common Duct Exploration

As with the previous series, I am concerned about the relatively small number of common ducts explored. A total of over 600 cases in the two series should be adequate to average the incidence of common duct stones. Yet instead of finding them in about 15% of cases where there are stones in the gallbladder, as reported by some, I have found them in only about 5%. I have three criteria for opening the common duct, palpable stones, enlargement of the duct or a history of jaundice. I do not routinely explore the common duct simply because stones are present in the gallbladder regardless of their size. I feel that opening the common duct is not an innocuous procedure. Its vascular supply is intimately adherent to the wall of the duct and further if the duct is small and not dilated post-incisional contracture may be of some appreciable degree. So far as X-ray studies at the opating table are concerned, I have used the procedure hardly at all. I would appreciate a discussion first as to its usefulness in cases where no stones are palpable in the common duct and secondly the percentage of negative findings secured. Are its results worth the extra time and trauma required?

I have, of course, resorted to post-convalescence cholangiograms in patients who are not symptom free after surgery. In most instances, this is a most satisfactory examination in the visualization obtained. So far, in only one instance, has a stone been demonstrated in a patient whose common duct was not explored when stones were present in the gallbladder. Since the patient had complete relief for six years following the cholecystectomy it could be that the stone was not present at the time of the first operation. How many patients have gone to other surgeons I, of course, have no way of knowing.

While the convalescence after the ideal cholecystectomy, in which no drainage is employed, is most gratifying, I still drain all cases. Biliary peritonitis without drainage can be quite serious and may result not only from a slipped ligature on the cystic duct stump but also from tiny bile radicles in the exposed liver surface.

Words of Caution

I have learned the hard way to avoid the unnecessary freeing of adhesions, especially those which cannot be visualized. Often adhesions in the right upper quadrant will have to be freed to expose the gallbladder, release the duodenum, etc. Failure to do this may result in an inadequate operation. On the other hand, adhesions palpated in the pelvis are particularly dangerous to attempt to free. In trying to do so one is likely to violate the precept of adequate visualization of all structures attacked. Fistulae, oozing, and subsequent re-formation of adhesions which may cause serious symptoms are complications likely to occur.

One who attempts to do gallbladder surgery must be competent to take care of a multitude of lesions which may mimic gallbladder disease or occur concurrently or independent of it. In the series reported today it was necessary at the time of gallbladder surgery to explore the stomach or duodenum, resect the stomach, repair a hernia, anastomose the gallbladder and jejunum, close a colonic fistula, repair traumatized ileum, excise a liver tumor, and drain pancreatitis.

Acute cholecystitis in its various phases, with or without stones or gangrene comprised about 7% of the cases. I have seen no reason to change the concept of the disease as an urgent rather than an emergency or elective disease. None of the patients in this group died after surgery. Early surgery is safe and the morbidity is low. The same is true of late surgery if the patient subsides satisfactorily. Most difficulties are incurred when intermediate surgery is required in a patient who has passed the time for early surgery but whose disease will not subside.

Since much of the digestive distress in gallbladder disease is probably due to contractions of the gallbladder after the ingestion of fatty foods, I have never felt that there was much indication for a restricted post-operative diet where there is no gallbladder left to contract. For that reason, I allow my patients to eat anything that ordinarily agrees with them. The usual comment made at follow-up visits is that the patient eats "everything" or "foods that I haven't been able to eat in years."

Conclusions

Because of the increasing number in the older age group and the increasing frequency of malignancy, there is no decrease in the incidence of gallbladder disease.

The results of gallbladder surgery are among the most satisfactory obtainable in any type of surgical disease.

Familiarity with its various procedures should not encourage the surgeon to minimize at any time the importance of being constantly alert for anomalies and unsatisfactorily visualized structures—nowhere in the field of surgery can accidents be so disabling.

Perhaps the greatest difference of opinion and experience in gallbladder surgery is concerned with the management of the common duct—especially when to X-ray on the table and when to explore.

The Surgeon's Responsibility For The Surgical Specimen*

James T. McClellan, M.D.; M.S.**

Lexington, Ky.

THE surgeon giving his undivided attention to the operative field and his patient is likely to neglect the surgical specimen and as a result the specimen may reach the pathologist in a poor state of preservation. Also, the accompanying information may be meager, lacking, or even inaccurate and misleading. The surgeon is then denied the full benefit he could receive from the pathologist's consultation. While the primary object of the operation may be to relieve the patient of a certain amount of abnormal or diseased tissue, an equally necessary portion of the surgeon's duties is to inform his patient of the nature and extent of the disease. It therefore follows that the surgeon cannot fully discharge his responsibility to his patient without assuming proper responsibility for his surgical specimen. Besides the immediate care of the patient there are certain secondary responsibilities of a practicing surgeon in this modern day of integrated medicine. These include:

1. Self training to better recognize abnormal and pathological states.
2. The surgeon's individual responsibility for the continued training of his pathologist so that this pathologist can continually render better service to the surgeon and his patients.
3. The training of the surgeon's hospital house staff and technical assistants.

*Read at the meeting of the Kentucky Surgical Society, French Lick Springs, Indiana, 5-16-59.

**Department of Pathology, The Lexington Clinic and Department of Bacteriology, University of Kentucky.

In order to fulfill these obligations in surgical practice a few principles of pathology laboratory procedure must be pointed out. These principles appear obvious yet a few hours spent in most any pathology laboratory should convince most surgeons that these principles are not obvious, at least to some.

The surgeon must consider the pathologist another consultant with his patient such as the anesthetist, the internist, or any of the other specialists or practitioners called in. Just as any physician requires information about his patient, the pathologist needs some information and is frequently not in a position to get this for himself, particularly when the surgical specimen is submitted from a distance through the mail.

The Requisition

Many diseases are peculiarly associated with different decades of life, different sexes, and specific parts of the body; therefore, in order to acquaint the pathologist with the essential information a proper requisition must accompany each surgical specimen. The requisition will vary with each individual laboratory or pathologist but should present the following information.

1. *THE NAME:* The patient's name should be presented in full and according to rules of proper hospital admission procedure. For a man the legal name which includes the first name, middle initial, and last name is usually sufficient. The name of a married woman may cause difficulty and inaccuracies in reporting

when specimens may be registered for her under a variety of names. "The Manual for Medical Record Librarians"[1] recommends the legal name of a married woman to be used, followed in parentheses by the given name of her husband. This means the requisition should show her given name plus her surname acquired at marriage, followed in parentheses by Mrs. and the given name of her husband. This will differentiate reports on people of similar names.

2. *THE AGE:* The age is extremely important for proper interpretation of pathological material. Occasionally the age is not known; however, the pathologist should not be denied the observations of the surgeon who can state the approximate age such as child, young adult, middle aged, 50 plus or elderly.
3. *THE DATE:* On a current report the date may appear to be of little significance; subsequently however, dates of operations may be of considerable value. Hospital record rooms and pathological laboratories commonly file reports and information on patients in year by year files. Undated year end specimens may cause reports to be filed in the wrong year and thus they might not be found on request.
4. *IDENTIFYING DATA:* The patient's address, hospital admission number, room number, and other specific information concerning a patient might at times be extremely important to the surgeon or to the hospital in identifying a report with a specific chart. Experience has shown that this information is rarely obtained.
5. *SEX AND RACE:* While the sex and race of the patient may seem to be trivial data, there are times when the sex or the race of the patient is of considerable importance in a specific diagnosis. The sex of a patient can frequently be determined from the patient's name; however, there are numerous names which do not indicate a patient's sex and the pathologist may lack this specific information.
6. *THE HOSPITAL:* Requisitions from a distant hospital to a pathology laboratory should in some way carry the name and address of the hospital to which the report is to be sent.
7. *PRE AND POSTOPERATIVE DIAGNOSIS:* The Joint Commission for Hospital Accreditation requires that a preoperative diagnosis be made before surgery is undertaken and this information be placed on the patient's chart. The pathologist is entitled to this information and it should be placed on the requisition. Sometimes, for the pathologist, the postoperative diagnosis is the most helpful and the preoperative diagnosis may be actually misleading if it alone is submitted. Occasionally a surgeon will still find difficulty in expressing a pre-or postoperative diagnosis; however, there still remain certain reasons which forced the surgeon to operate and these may be very helpful to the pathologist. A specific example of this might be "uterine bleeding." Such terms may not be entirely acceptable as diagnostic terms; however, they give the pathologist a great deal of necessary information in examining the specimen.
8. *SPECIFIC TISSUES REMOVED WITH LOCATION:* The requisition should list all of the tissues or organs which the surgeon has removed, whether diseased or not. The pathologist acting as a disinterested third party can legally verify the fact that the structure was removed. This fact may subsequently be of great importance to the patient and is reason enough to warrant the pathologist's examination of the tissue.
9. *REMARKS:* Specific information about the patient's disease or treatment may influence the interpretation of the material and will be of great benefit to the pathologist.[2]
10. *TYPE OF EXAMINATION REQUIRED:* Most laboratories have a routine way of doing things and therefore a set routine time when a report can be expected. Some tissues require gross examination only for recording that certain tissues have been removed. A frozen section may

not only give a rapid diagnosis but may allow specific therapy to be instigated at an earlier date or may decrease the patient's hospitalization period.

11. *THE SURGEON'S NAME:* A request for pathology consultation should have the surgeon's name written in a legible fashion so that it can be identified and correctly placed upon the report. The frequency with which the surgeon's name is omitted from pathology requisitions indicates the lack of attention given to the requisition.

The Specimen

Unless the surgical specimen can be delivered to the pathology laboratory immediately, the specimen must be placed in a fixing solution and the container labeled with the patient's name, the specimen, and the physician. Labeling of the specimen container is important in protecting the surgeon and the referring hospital from subsequent mix-ups and mistakes should such occur. The referring surgeon or hospital has little recourse if they have failed to label properly a specimen container. The specimen container should be of sufficient size to accommodate the specimen. It must be remembered that tissue becomes quite hard, taking on somewhat the consistency of leather, when it is left in a fixative. The pathologist appreciates being able to remove the specimen from the container without first breaking the container away from the specimen. A soft specimen may be inserted easily into a bottle from which it cannot be removed once it has hardened. As a general rule, a surgical specimen should be placed in approximately ten times its volume of fixing solution. If this cannot be accomplished the specimen should rapidly be submitted to a pathology laboratory where the specimen may be examined and the fixing solution changed.

Containers and fixing solution are usually supplied by the laboratory to which the specimen will be submitted. The type of fixative will depend upon the preference of the laboratory; however, I know of no pathology laboratory which cannot examine adequately specimens submitted in 10% formalin solution. Formalin is a solution of 37 to 40% by weight of formaldehyde gas (HCHO) in water, usually with 10 to 15% methanol added to prevent polymerization. A 10% solution of formalin is, therefore, approximately a 4% solution of formaldehyde gas in water. Satisfactory solutions of formalin fixative are made by diluting one part of commercial formalin (37 to 40% formaldehyde) with nine parts of tap water. Since this solution is so easily prepared, there is no reason for ever submitting a surgical specimen in the concentrated formalin solution. Solutions of formaldehyde have marked germicidal properties as well as the properties for fixing or coagulating protein. Specimens placed in adequate amounts of formalin solution and adequately packed are acceptable for mailing by the postal authorities.

Evidently situations arise in which solutions of formalin are not available and makeshift fixative must be used. Most drug stores can supply 10% solution of formalin. Alcohol, particularly rubbing alcohol, is not a satisfactory fixative in which to submit tissue specimens. Alcohol is also a dehydrating agent and specimens left in alcohol become extremely hard and brittle. Furthermore, only the outside will be fixed since there is very little penetration. A more satisfactory substitute for the pathologist's fixative is arterial embalming fluid as prepared by any embalmer for arterial injection.

Specimens to be submitted in the fresh state to the pathology laboratory should not be placed in water or saline solution. There should be no more delay than necessary in reaching the pathology laboratory.

The reason for fixing a specimen is to coagulate the protein in the tissue. Proper and adequate fixation will preserve tissue almost indefinitely. In order to do this the fixing solution must reach the tissue and under no circumstance should the tissue be wrapped tightly in gauze before placing it in fixing solution. Whenever possible, fragments of tissue should be removed from gauze on which they are placed at the operating table. If this does not appear to be practical the specimen should be placed in a sufficiently large container to fluff out the gauze and allow the fixing solution to reach the specimen.

Large specimens should be sectioned and hollow viscera should be opened. The contents of hollow viscera should be washed away so that the mucosa will be penetrated by the fixing solution. A pathologist does not like to receive a specimen all cut up; however, a specimen sec-

tioned neatly in two equal parts can only cause the consultant pathologist to praise the thoughtfulness of the submitting surgeon since this allows for adequate internal fixation.

Some hospitals fix their larger specimens in a crock or large container of formaldehyde before mailing to the pathologist. The surgical specimens are rinsed in cold tap water, sectioned or opened as necessary, the specimens are tagged with an identifying tag attached to a piece of strong, light cord. The cord is tied around an unimportant region of the specimen or inserted through the specimen by means of a needle. The specimen is then suspended in a large container of formalin solution for twenty-four hours or more until fixation is complete. After this the specimens are individually wrapped in wax paper, Saran wrap, aluminum foil, or placed in plastic bags with a small amount of formaldehyde and sealed by tying the top with a strong rubber band. This method allows the specimens to be submitted with minimum postage; however, fixation before mailing obviously increases the time required for the pathologist's consultation to reach the hospital chart.

It is hoped that these suggestions will be found helpful to many surgeons who practice in hospitals not staffed by a pathologist. From the standpoint of a practicing pathologist these suggestions are submitted to help the surgeon obtain the maximum pathological consultation.

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Catalase Activity Studies: A Screening Program for Chemotherapy Failures in Tuberculosis Treatment

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ADEQUATE and appropriate chemotherapy in the initial treatment of pulmonary tuberculosis can approach 99 per cent success.[1,2] This has resulted from improved bacteriological control and from a mode of therapy based more on individual requirements. Indeed, in many instances, if sputum examinations remain heavily positive for tubercle bacilli after 6-8 months of combined treatment, then one can seriously question the adequacy of such a combination. Inadequate therapy can fail either by the drugs having no antimicrobial effect, or by allowing the early emergence of drug resistant mutants.

Value and Use of Test

As many sanatoria may not be well equipped for drug susceptibility studies, catalase activity tests could well be adapted as an aid in the management of tuberculous patients. Catalase, an enzyme synthesized by the tubercle bacillus and other aerobic bacteria, reacts with hydrogen peroxide to liberate oxygen and water. The correlation between isoniazid (INH) dosage and catalase activity studies as described by Middlebrook and co-workers has been a most important finding. Cohn et al.[3] have shown that isoniazid resistant mutants can be either catalase positive or negative; but only catalase negative INH resistant mutants emerged on exposure to high concentrations of isoniazid. Mandel et al.[5] have carried out studies on the microbiologic serum level of isoniazid and have shown that patients excreting catalase negative mutants have achieved higher microbiologic levels of INH.

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A simple test is thus available whereby physicians can keep a monthly check on sputum examinations for chemotherapy failures at an early stage. I have had the opportunity to study a small group of patients at this institution. Forty three patients were found still positive on culture of typical M. tuberculosis after chemotherapy had been given for periods ranging from 7 to 48 months; 75% of the cases having received over 10 months of treatment. Resistance to drugs in most of these cases was suspected as the basis for these persistent positive cultures. Drug susceptibility studies could not be carried out in all cases because of discharges, transfers and surgery. However, sensitivity studies have since been obtained in 17 of these patients and all were resistant to isoniazid or streptomycin or both of these drugs.

Catalase studies were carried out in this group of 43 patients, some of them having as many as six cultures examined. In those who had received over 10 months of treatment, the positive and negative catalase reactions appeared more or less equally distributed. Table I shows positive reactions in 23 patients and negative in 17; the phenomenon of different cultures from the same individual yielding both negative and positive reactions was encountered in only 3 cases[4]. Most of the patients were apparently receiving inadequate INH dosage, and this is borne out by the greater number of catalase positive reactions after so many months of treatment. Four out of 6 in the S_2H treated group, compared with only 5 out of 11 in the PH treated group, manifested entirely catalase positive reactions. This is probably explained by those in the latter group having achieved a higher level of serum INH because of the association of para-aminosali-

TABLE I: Analysis Relative To Drug Regimens

TYPE OF CHEMOTHERAPY (Courses)	NUMBER OF CASES	DISEASE CLASSIFICATION			DURATION OF TREATMENT (Months)	CATALASE REACTION	
		FA	MA	MIN		POSITIVE	NEGATIVE
S_2H	6	3	3		7 — 20	4+ (1)	1+ (1)
PH	11	8	3		7 — 24	5	6
S_2H, PH	21	14	7		7 — 48	10+ (2)	9+ (2)
S_2P, PH	4	3	1		15 — 24	3	1
S_2P, S_2H, PH	1	1			30	1	—
	43					23+ (3)	17+ (3)

S_2H: Bi-weekly streptomycin with daily isoniazid in conventional dosages.
PH: Daily PAS with isoniazid in conventional dosages.
S_2P: Bi-weekly streptomycin with PAS in conventional dosages.
Bracketed figures represent cases that yielded both positive and negative reactions on separate culture.

cylic acid (PAS) with the isoniazid, in the initial treatment. It should also be pointed out that not one patient in this series was treated with daily streptomycin and daily isoniazid.

Thoracic surgery was carried out in 20 of these patients—12 far advanced and 8 moderately advanced cases. As seen in Table II, eight patients had surgical complications, another five have since reactivated and have positive sputum examinations, and one died from tuberculosis following a prolonged illness; six of the patients are well. A large number of failures in this small group can be explained only on the basis of highly positive sputum, drug resistant in most of these cases. The number of failures is smaller in the catalase negative group, and this is probably important from the point of view of selection of cases for surgery, and timing of the procedure.

Method

All precautions being taken, the following was the method used. A moist colony of tubercle bacilli was placed within a drop of H_2O_2 on an ordinary slide. This was then observed for "bubbling"; a minimal reaction can best be seen through a magnifying glass. The degree of reaction is better judged with experience as +, ++, +++ or "no reaction." The results were confirmed by dropping H_2O_2 on the actual Lowenstein-Jensen slopes, though the slide method has been found more convenient to interpret. A small colony of tubercle bacilli is adequate for test purposes. Nearly 400 test have been carried out, and results have been found consistently reproducible. As expected, newly diagnosed cases always exhibit a catalase positive reaction of varying degree. On the other hand, many of the old cases who

TABLE II: Surgical Cases (20)

CATALASE TEST	POST-OPERATIVE COMPLICATIONS	RECURRENCE WITH POSITIVE SPUTUM	DEATHS	WELL ON REVIEW
POSITIVE	5	2	1	3
NEGATIVE	3	3	0	3
	8	5	1	6

already had received chemotherapy elsewhere, showed a negative catalase reaction; though a substantial number, as in the group of cases discussed here, were still catalase positive on admission, indicating inadequate chemotherapy.

In the treatment of tuberculosis one aims for complete control of the disease. If this cannot be achieved, a catalase negative state is still desirable in a sputum positive patient; as animal experiments have demonstrated that catalase negative tubercle bacilli have been found consistently less pathogenic [5,6]. In a dual drug combination if isoniazid dosage is adequate, catalase activity should be deficient even though drug resistance may develop if the companion drug is insufficient as is often the case with intermittent streptomycin. On the other hand, if isoniazid dosage is inadequate, then the catalase reaction will usually be found positive, indicating a lack of antimicrobial effect. Increase in isoniazid dosage does not usually affect the catalase state of the isoniazid resistant mutant once this is established[7].

Drug Combinations

The subject of combinations of antimicrobials in tuberculosis is still quite controversial[8,9]. Daily streptomycin with daily isoniazid is recognized by many authorities as the best combination we have today. It is of great value to iron out differences and establish this principle; and also to assess the significance of high isoniazid dosage[10,11]. This is obviously to the patient's benefit as the prognosis is directly related to initial treatment. We are today seeing more and more patients suffering from far advanced pulmonary tuberculosis excreting large proportions of drug resistant tubercle bacilli. In a substantial number of these cases the initial treatment was probably inadequate.

Catalase activity studies should be more widely used in conjunction with other bacteriological examinations. Whenever possible drug sensitivity studies should be obtained on all patients. When a positive sputum patient still shows a positive catalase reaction after several months of chemotherapy, one can adjust the drug dosage, for instance increasing Streptomycin to 1 gm daily and INH to 16 mgm/kilo bodyweight. On the other hand, a persistent positive culture with a negative catalase reaction can in most cases be considered for a change of antimicrobial agents, such as Cycloserine + Pyrizinamide + INH; or Kanamycin may also be considered. Ostreicher et al. [6] have described how one of the actions of isoniazid is to attack any drug susceptible reverse, mutants which may make their appearance from drug resistant populations of tubercle bacilli. This is the advantage of maintaining INH in such a regimen. This plan could well cover most of those patients already under treatment for several months and showing no signs of bacteriological conversion. For those recent or newly diagnosed cases, however, the strong recommendation is for an initial period of treatment with streptomycin 1 gram daily, isoniazid 16 mg/kilo body weight and Pyridoxine 50 - 100 mg. daily for at least 3 months. In the absence of serum drug level determinations, daily PAS should also be added to such a regimen, to cover such cases as prove to be very rapid INH inactivators. The same principles of bacteriological control would also apply.

Conclusion

In conclusion one can express the hope that such a scheme in the absence of a first rate up to date bacteriology department, may provide a closer check on the response to chemotherapy. The individual failure could then be re-assessed without undue delay. It is to be noted that recent reports on the new antimicrobial agents have shown encouraging results in a percentage of retreatment cases. A number of the group reported here have since been put on a different combination of drugs and the results will be analyzed elsewhere. Another obvious benefit is that in the long run, some patients would be spared a prolonged stay in the hospital and thus be returned earlier to their families and occupations. This very important factor cannot be lost sight of in the management of tuberculosis patients.[12]

Summary

A simple method of carrying out catalase studies on positive cultures is described. It is suggested that this test could be more extensively used and possibly serve as a guide for the detection of early therapy failures. Steps to deal with such failures are also outlined.

An analysis of 43 patients who were persistently positive for tuberculosis after many months of chemotherapy is presented. A correlation between failure to respond to treatment and type of initial therapy is suggested; as well as an increase in post-operative complication rate on cases coming to surgery who are sputum positive, drug resistant, and catalase positive.

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Two Hundred Selected Vaginal Hysterectomies and Anterior and Posterior Repairs, With Discussion Of Technique Changes and Complications*

W. O. Johnson, M.D.

Louisville, Ky.

VAGINAL plastic surgery is reconstructive surgery, requiring accuracy, symmetry, and neatness in its execution. Stimulated by the works of Kennedy, Mayo's, Heaney, and others, it has reached its state of perfection. The advantages of ¼ of 1% mortality, low morbidity, less shock and fewer serious complications, absence of abdominal scars and omental adhesions, smooth and shorter convalescence, make the vaginal approach ideal when possible. Modern cancer education with special emphasis on prophylaxis and early cure cause patients to become more conscious of the dangers and neglect of pathological conditions, therefore, they seek medical advice earlier.

Vaginal relaxations and their sequels are not necessarily the result of obstetrical neglect, but may result from an inherent weakness of the tissues before or at the time of delivery. Some nulliparous women have prolapse of the uterus. The process is essentially the same from a vaginal weakness to a complete prolapse, but varies only in degree.

Cystocele and rectocele are direct traumatic herniae, in the dependent portion of the body that contains the exits of the urinary, reproductive, and gastro-intestinal systems. Therefore, these hernias must have the accepted procedures for the hernia repair, to enable the systems involved to function properly.

Pre-Operative Preparation

Pessaries are used before operation to show the individual that by the proper support, the symptoms can be relieved. During this time anemias are treated by supplementary diets, iron and hematinics, and transfusions if necessary. Having the patients cooperation before surgery insures better convalesence after the operation and also better end results. Some of these cases used pessaries for months, under careful supervision, the operation being done when the patient was in the best physical and emotional condition.

Symptoms

The complaints are not numerous and the patient usually comes in with her own diagnosis, "Falling of Womb," "backache."

The largest number of symptoms are associated with pelvic congestion and dysfunction of bladder, causing retention of urinary sediment in the bladder and infection or irritation. These symptoms progress until function is controlled or restored. Symptoms were present from one week to two years before operation.

CHART No. 1

Chief Complaint	Percentage
1. Abdominal Pain, Pelvic Pressure, Backache	39.0
2. Uterine and Bladder Prolapse	26.5
3. Vaginal Discharge	25.5
4. Abnormal Bleeding	22.5
5. Urinary Symptoms (Dysuria—Incontinence)	12.0

Age and Anesthesia

The ages of the patients varied from 29 to 73 years, with an average of 48.6. Their weights ranged from 97 to 256 pounds, with an average of 150. Twenty-seven patients had had only one child, and one had had ten, the average being three.

Most of these patients had spinal anesthesia (194 cases) and the rest (6 cases) general anesthesia for various reasons. The average duration of the anesthesia was one hour and 30 minutes. The shortest duration was one hour and the longest was two hours and ten minutes. This time element is of greatest importance in the aged patients.

*Presented at the annual meeting of the Kentucky Surgical Society at French Lick, Indiana, on May 15-16, 1959.

Laboratory Findings

Over 86% of the cases had a hemoglobin of 80% or over when they came to operation with over 4,000,000 R.B.C. before operation. This was accomplished by medicine or transfusion. Ninety-three transfusions of blood were given in these 200 cases.

Steps In Operation

The steps of the operation should at all times be in full view. The bladder is first dissected from the anterior wall of the vagina and the uterus, then the uterus is exposed, explored, and removed.

The important steps in anterior repair are the overlapping of the round and broad ligaments in the mid-line, giving a good pelvic sling in the mid-pelvis. Then follows overlapping of the cardinal and uterosacral ligaments by O chromic cat gut sutures. If there is a weakness in the posterior cul-de-sac, two to three smocking cat gut sutures, fixed to the uterosacral ligament dome, give support and prevent enterocele, without shortening the vagina. This makes a pelvic sling.

The bladder fascia (or the inferior urogenital fascia) is plicated by approximation of bladder pillars, at the base, attaching them to cardinal and uterosacral ligaments. Overlap the structures from below upward and then by three interlocking sutures make a periurethral sling of tissue to obliterate the uretheral weakness. This gives a fascial floor for the anterior wall, which is then covered by approximation of the anterior vaginal mucous membrane.

The posterior vaginal mucosa is dissected wide until the fascia is isolated, then dissected free. An edge is brought up and attached to the edge of the perineal fascia by interrupted chromic cat gut sutures. In young people this may be sufficient, but, if there is bulging of the anterior rectal fascia, this is strengthened by smocking sutures of chromic cat gut, up to the dome of the vagina. This will give the desired results. The levator ani muscles are then easily visualized and nearly approximated with interrupted cat gut sutures loosely placed. The rectum is dilated manually to admit two fingers to prevent post-operative spasm and allow drainage of hemorrhoidal veins and early passage of gas. The vagina is packed with plain gauze for 48 hours, and a retention (Foley) catheter is used for 5 days.

Pathological Findings

Uterine Fibroids	45 Cases
Polyps (17 Cervical, 25 Endometrial)	42
Senile Atrophic Changes (Vascular Fibrosis, Cystic Cervicitis)	33
Secretary Endometrium—Chronic Cervicitis	20
Adenomyosis	6
Fibroma of Ovary	5
Cervical Erosions	5
Ruptured Ovarian Cysts	3
Salpingitis and Oophoritis	3
Dermoid Cyst of Ovary	1

The pathological findings speak for themselves. But there are two striking findings—the large number of endometrial polyps, and the small number of reported vascular changes in the uterus. These were all out of proportion to the symptoms.

During the hospital stay, 93 out of 200 cases were given blood transfusions, seven pints of blood being the highest number of transfusions given to any one patient. No blood was given during anesthesia. Transfusions were usually given before and after operation when possible and needed. When two transfusions were given, the blood was rechecked and cross-matched before more was given. There were 5 slight transfusion reactions in this series. Sixty-five per cent of this series of selected cases had no morbidity as judged by accepted standards. Sixty-eight per cent of the 200 cases were post menopausal (3 months to 22 years).

Vaginal packing was removed in 48 hours after operation, but, if the temperature rose to 102° the first night, the packing was removed. The catheter (retention) was usually left in for 5 days.

Hospital Complications

Cystitis and Urethritis (Cleared in Hospital)	48 Cases
Pyelitis	12
Postoperative Hemorrhage (4 on 8th, 1 on 15th Day P.O.)	5
Perineal Infections	5
Cul-de-sac Abscess	5
Thrombophlebitis (Left)	4
Thrombosed Hemorrhoids	4
Peri-Urethral Abscess	2
Bronchopneumonia (Atelectasis)	2
P.O.—8th Day Intestinal Obstruction (1 Flare-up Appendix, 1 P.I.D.)	2
Slough of Post Vaginal Wall	2
Polyp and Adenocarcinoma	2
Known Cases of Diabetes	4
Total	97

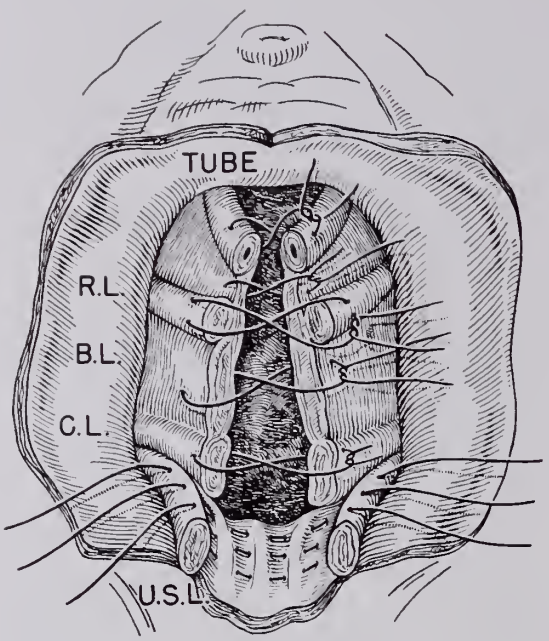


Figure 1

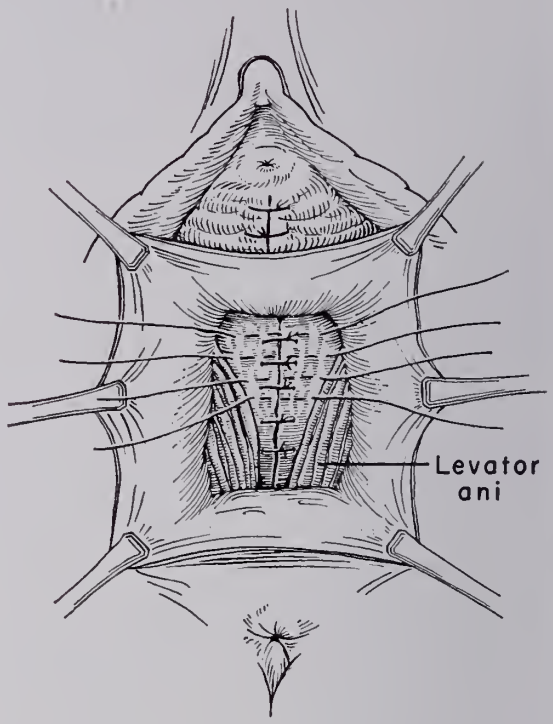


Figure 3

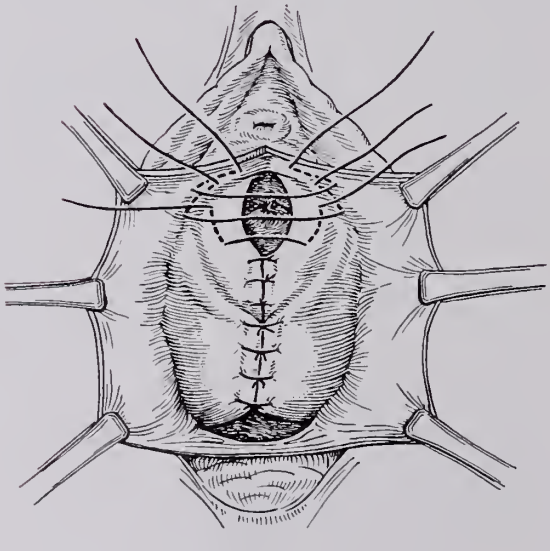


Figure 2

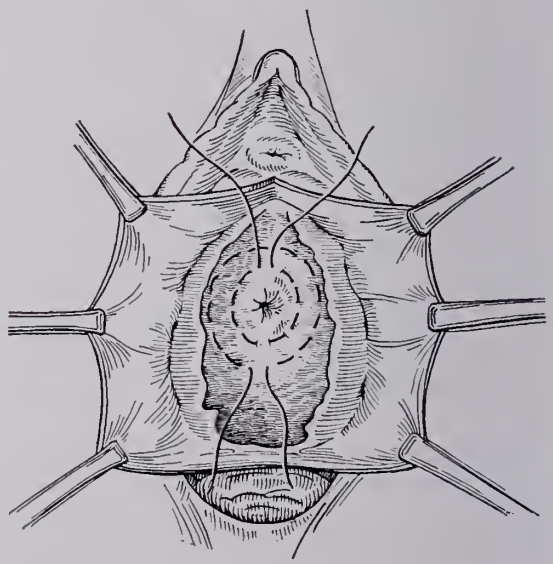


Figure 4

Post operative cystitis and urethritis is present in almost every case, because of bladder retention and infection of long standing, because of the operative manipulation and because of the presence of a foreign body (catheter). Most of them clear up by the second day after the removal of the catheter on the 5th day. The severe cases are the ones that plague you. They should be treated with either antibiotics, bladder irrigation, or a combination and will usually clear up on the 9th day.

Those who don't respond result in swelling, ascending infection, and pyelitis. In such cases G. U. consultation is warranted for kidney drainage and irrigation.

Follow-up Findings

Satisfactory Results	192	Cases
Repair of Enterocele (6 months - 3 Years)	3	
Recurrent Cystocele (1 Year)	2	
Coccygodynia (Corrected) (6 Months)	1	
Neuroma Perineum (Corrected)	1	
Shortened Vagina (Dyspareunia)	2	
Post-Coital Vaginal Rent 6 Weeks After Operation	2	
Heart Failures (No Deaths)	5	
Exaggeration of Emotional Problems	20	
Recovery Retarded by Family Illness	14	
Fungal Vaginitis (Cleared after Treatment and Stopping Antibiotics)	6	
Carcinoma of Cervic (In Situ)	1	
Vaginal Dome Granulations	42	
Urinary Hesitancy (Later Controlled)	11	

Even with most meticulous initial care, postoperative hemorrhage occurs, usually at the right angle of the cuff of the vagina. It is most frequent on the fourth to the eighth day, and can usually be controlled by vaginal packs. In others this offending vessel has to be ligated.

In spite of all precaution, infections and abscess will occur in the perineum and other areas where necrosis and breaking down of tissue are present. In cases of drainage due to use of antibiotics, hot douches usually give satisfactory results.

Thrombophlebitis is an ever present threat. Patient's legs are wrapped to the thigh during the anesthesia, and for two days after operation. I have operated on two cases that had thrombophlebitis before and they have become symptom free.

Appendical abscesses have occurred and drained. Intestinal obstruction is treated as in other abdominal operations, released, resected, or alleviated. Post vaginal wall slough was the result of senility and poor circulation, and hormones and grafts revived the circulation.

Diabetic cases are always brought under control by a medical man before operation, and are under his supervision after. This has prevented many complications.

When properly selected, vaginal hysterectomy and anterior and posterior colporrhaphy will give 96% satisfactory results but it is not free from its headaches. About 4% of the cases, because of the weakness or poor healing, will, in a period of six months to a year have a recurrence of cystocele or presence of enterocoele. These should be repaired early. Due to fibrosis, and poor tissue tone and circulation, there is shortening of the vagina. In that these patients are post menopausal, they are subject to circulatory failure, which is a cause of some healing changes and fibrosis.

In a very high percentage of patients in whom vaginal hysterectomy is indicated, there is also a definite indication for repair of cystocele and rectocele. If this is not included in the operation the results are not satisfactory. If there is pathology high in the pelvis, better removal and results can be obtained by abdominal hysterectomy. I have twenty cases that have had, over a long time, psychoneurotic patterns that are known and used as escape mechanisms by the patient. After the operation, these became fixed and more pronounced and yet there were definite indications for the operations, and in spite of this complication the operations benefitted the patients. This association must be kept in mind, avoided when possible and treated or faced when recognized, for it plays an important part in the end results.

Summary

1. Presenting 200 cases of selected vaginal hysterectomy and anterior and posterior colporrhaphy done by the author.

2. Presenting complications encountered in this series of selected cases.

3. Presenting improvements in technique in the past ten years along the lines of repair of direct traumatic hernia in dependent parts of the body.

4. Abdominal and vaginal hysterectomy are in no sense comparable. Each has its indications and contra-indications, based on the findings present and the training of the gynecologist.

The Management Of Maxillofacial Trauma

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In a broad sense, maxillofacial injury implies damage to the supporting skeletal structures of the face. Such injury may be relatively simple, involving only one or two facial bones with or without displacement, or may involve one or more facial bones with severe comminution. Either relatively simple or severely comminuted fractures may occur with or without lacerations. Except with the mildest injuries, head injury should be considered a possible complicating factor and, when present, should take precedence over all other disabilities if life is to be preserved and maximum neurologic rehabilitation achieved.

Diagnosis

No one method of diagnosis of facial injuries is adequate. Since any method usually gives only part of the total picture of injury, the history, if available, will be of some value. For example, an automobile accident victim's position in the car may have determined what structures his face struck; the angle of the collision, the manner in which the victim was thrown. Knowledge of such factors will often suggest the type of injury which the patient may have sustained and direct the search for possible injury to certain areas.

The first step in examining the patient should be a general inspection to be sure that no critical condition, such as shock, head injury or respiratory difficulty, is overlooked. Next, looking at the patient may reveal signs of gross displacement of various structures, such as depression or deviation of the nose. Depression of the cheek and/or downward displacement of an eye indicates fracture of the maxilla and zygoma. In a normal person the medial and lateral palpebral angles of both eyes lie in a straight line. Fracture of the jaw may cause deformity or lateral displacement of the jaw. Limitation of opening or closing the mouth will be encountered when depressed fractures of the zygoma impinge on the coronoid process of the mandible. Abnormal mobility of the teeth also will suggest fractures involving the upper jaw.

Edema and interstitial hemorrhage will be a limiting factor in uncovering injuries by inspection. Palpation will confirm many of the findings of inspection and uncover other fractures with gross displacement. Tenderness over the temporomandibular joint should suggest a fracture of the condyle. Here, as on inspection, edema and interstitial hemorrhage make evaluation difficult. Grasping and manipulation of the upper teeth will determine the presence of fractures of the inferior portion of the maxillae. X-rays, because of the multiple superimposed skeletal structures, may not demonstrate all fractures, and often fractures are difficult to determine by standard techniques. Frequently gross displacement will not be evident, even when fractures are demonstrated by inspection and palpation. The combination of all aspects of examination will give a good estimate of the damage and make planning of adequate reconstructive surgery possible.

General Management

Methods of management will vary according to the severity of the injury. For example, injuries consisting primarily of a fracture without displacement of the facial bones or nasal bones will require no treatment other than general supportive measures and reassurance. Injuries which result in fracture of multiple facial bones may be so severe as to defy cosmetic and functional rehabilitation by any means. If perforating injuries or lacerations of the facial tissues have occurred, prophylactic treatment with tetanus antitoxin or tetanus toxoid is indicated. If, as is often the case, the wounds are particu-

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larly dirty and severely traumatized, the possibility of gas gangrene must be anticipated and prophylactically guarded against.

In severe trauma, one must first deal with impending respiratory obstruction, which may be an immediate life-endangering problem. In severe injuries it may be necessary to insert nasal packs and to wire teeth in occlusion. Since these procedures may interfere with breathing, prophylactic tracheotomy must be done. In addition to assuring an adequate airway, the tracheotomy allows easy aspiration of the tracheobronchial tree and aspiration of emesis, a frequent accompaniment when severe injury about the head has occurred. Bleeding may, on occasion, be quite severe, necessitating treatment for shock. Anemia from hemorrhage may be so severe as to make anesthesia hazardous. Thus laboratory studies plus careful preoperative medical evaluation of the patient are essential, if the physician is to avoid compromising an already seriously threatened individual's chance for recovery. Although there is much to be said in favor of immediate surgical correction of these injuries, a delay of up to two weeks or even a month will result in only slight impairment of functional and cosmetic results.

Management of Specific Injuries

Fractures of the nose—Injury may involve the entire nasal pyramid and nasal septum. If the blow was toward the nasal spine and columnella, the injury may involve only the nasal septum and nasal spine. The majority of either type of fracture will respond readily to simple manipulation of the bones and nasal septum into their normal relationship with temporary packing and external splinting. If previous deformity of the nose and nasal septum were present, reduction to an ideal position may be impossible. Previous deviation of the septum with a straight nose may, after injury, result in a tendency to displacement of the nose by a crooked septum. In such cases, correction of the nasal septum by the septoplastic technique of Goldman will not only assure an unobstructed airway postoperatively but will also prevent the external nasal deformity from occurring. If previous nasal deformity was severe, the application of rhinoplastic technique, at the discretion of the physician and with the understanding of the patient, can achieve cosmetic and functional results superior to the pretraumatic condition. When lacerations have occurred, meticulous attention to detail is necessary, as the long-term result may depend more on this than on manipulation of the skeletal supporting structure. Even with crushing injuries of the nose, postoperative results can be strikingly good. If partial avulsions of the nasal tissues have occurred, the possibility of early local pedicles should be considered and, when feasible, used, as they will greatly shorten the cosmetic rehabilitation of the patient.

Fractures of the jaw—Fractures of the jaw may be relatively simple fractures of the linear type, or they may be rather severely comminuted. In the simple type, usually there are two or more fracture sites, although a single fracture site may occasionally occur. They tend to occur at points of structural weakness in the mandible, such as the symphysis, or through areas where one or more teeth are absent, or through the angle of the mandible. One or both condyles may have been fractured, alone or with other mandibular fractures, usually through the neck or at the junction with the ramus. Secondary muscle spasm will tend to maintain the traumatic deformity, and this may have to be overcome before suitable reduction can be accomplished. If the teeth are present, they form a built-in exact dental splint. Interdental continuous loop wire ligatures about the teeth and elastic traction of teeth in occlusion or, when necessary, wire fixation will result in the best anatomical and long-term functional results. Meticulous attention to the pretraumatic occlusion of the teeth, as determined from study of the dental configuration and facets of the teeth, will avoid creating a permanent or semipermanent dental cripple. If the jaw is edentulous and intact dentures are present, circumferential wiring of the dentures in place and fixation of the dentures in their proper occlusion to each other will result in a good functional and anatomic outcome. If the lower jaw is edentulous and the condyles are intact, Kirschner wire fixation or open reduction and wiring will achieve excellent anatomic results. If the jaw is severely comminuted, special dental splints probably will have to be made for the best results.

When the condyles in an edentulous jaw are

fractured, the proper space relationship between upper and lower jaw must be maintained or ultimate prosthetic rehabilitation may be jeopardized. In these cases it is best to apply special dental splints. When the teeth are present and one or both condyles have been fractured, the teeth must be wired into occlusion and maintained in this position for at least two weeks, until muscle balance has been restored, if normal occlusion is to return. In the majority of cases, this is all that is necessary, even when the condylar fragment has been displaced. Because of the relationship of the facial nerve to the temporomandibular joint, open reduction of the fracture is an exceedingly hazardous procedure. It is probable that the majority of these fractures heal by fibrous ankylosis with formation of a false joint. In the occasional case where permanent functional disability occurs, condylectomy can be carried out without functional impairment.

Fractures of the maxilla—Fractures of the maxilla may be horizontal with the fracture line extending across both antra, resulting in a mobile upper alveolus. The injury may be unilateral, in which case it is usually a maxillozygomatic fracture, which may be relatively simple, with one or two fracture lines. There may be comminuted, bilateral, so-called pyramidal fractures of both maxillae. These usually are more or less comminuted fractures, and usually there is a fracture of the nose. In addition to the foregoing, from a dental standpoint, segmental fractures of the upper alveolar ridge may occur alone or in combination with a complete horizontal fracture. In the more severe of these latter, many of the teeth may be nonviable and their removal may be necessary. Interdental ligatures and fixation of the teeth in occlusion represents the most effective way of handling these fractures, even when the jaw itself is also fractured. With the marked tendency of the maxilla to fall in these and in the more complicated pyramidal fractures of the maxillae, suspension with wires extending from the upper alveolar ridge to the lateral orbital margin or suspension from a head cap will be indicated.

I personally favor suspension from the lateral orbital margins, since the patient is much more comfortable and there is not the hazard of shifting which is present with the head cap. In the simple unilateral maxillozygomatic fractures, any one of three methods will yield uniformly good results. These are (1) elevation by inserting a bone hook under the zygomatic arch, (2) transoral reduction with a heavy instrument, such as a uterine sound or Joker elevator, or (3) elevation via the temporal incision, as recommended by Gillies. When the fractures are severely comminuted, such measures will be of no avail or at best will give unsatisfactory reduction. Open reduction through lateral orbital incisions with wiring of the frontozygomatic sutures, which are almost always separated, and with wiring of other fractures which can be approached through this incision will be adequate to maintain reduction in a large number. In some, however, this will not be adequate, and open reduction of the infra-orbital margin through an infra-orbital incision also must be carried out. Recently it has been my experience that in fractures of this severity, better cosmetic results can be attained, with less danger of postoperative scarring, interstitial hemorrhage and infection, by elevating these fragments to their proper positions and by passing Kirschner wires transantrally from the body of one zygoma through to the body of the opposite zygoma. Even here, in an occasional case, an infra-orbital incision will be required and wiring of the infra-orbital margin will have to be done for maximum cosmetic results.

Occasionally, a fracture will occur in the arch of the zygoma alone. This must be reduced, chiefly for cosmetic reasons. Such a fracture, if severe, may require incisions over the fracture site and wiring of the fracture line. The facial nerve must be meticulously protected. The management of bilateral pyramidal fractures is essentially the same as that outlined for the more severe horizontal fractures of the maxilla. Here, however, the integrity of the lateral orbital margins on both sides has been intefered with. The associated nasal fracture and septal fracture are complicating factors, and severe hemorrhage is more liable to have accompanied these injuries. The management of the individual case will vary in some detail. However, the upper alveolus is always free-riding. One or both frontozygomatic sutures may have been separated, and practically all are comminuted fractures. Interdental ligatures and wiring of the teeth in occlusion must be

done. Wires are passed from the upper alveolar ligatures, deep to the zygomatic arches, and wired to the supra-orbital margins on each side, to bring the maxillae up and forward and to help avoid the "dish face" result which is a serious cosmetic sequel of inadequate reduction. Open reduction and wiring of individual fragments may have to be carried out, particularly those of the infra-orbital margins. In the more severe varieties, transoral approach to the antra with packing may have to be carried out.

As my ideas evolve on the management of these fractures, I feel that maximum cosmetic and functional rehabilitation may be achieved with a minimum amount of open surgery through the elevation of a maxillary fracture and, after checking the nasal fractures for alignment of fragments, then resorting to transantral Kirschner wire fixation, as previously described. Even here, antral packing may have to be done in a certain percentage of cases. Individual fractures, particularly of the infra-orbital ridge, may have to be wired to restore the normal anatomic configuration. The management of the nasal fracture will vary in no significant detail from that already discussed. Because of the severity of these injuries, the need for packing and interdental wiring of the teeth, tracheotomy should always be considered and, in most instances, should be done.

Multiple fractures of all facial bones—These are always comminuted. They are often complicated by lacerations. Interstitial hemorrhage and edema almost always occur. Head injury is often present and takes priority in treatment. Detailed consideration of this type of fracture would require the discussion of individual cases, as the problem will vary with the particular complex of injuries encountered. The basic principles discussed above under each type of fracture will apply in the given situation. For example, interdental ligatures and fixation of the teeth for fractures involving the upper and lower jaw, maxillary suspension by wiring the upper teeth and suspending these from the lateral orbital ridges or from a head cap, or the use of transantral Kirschner wire fixation for the management of fractures of the maxilla will be carried out according to the indication for each case. Where the teeth are absent, special dental splints may have to be devised and inserted. In my opinion, because of the severity of these injuries, tracheotomy should always be carried out as a prelude to this surgery.

Complications to Surgical Management of Maxillofacial Trauma

In the management of maxillofacial trauma cosmetic defects may occur as a result of improper closure of lacerations or as a result of infection due to invasion of the damaged tissues by pathogenic bacteria. Residual skeletal deformity may result from inadequate reduction of fractures. In the severe fractures with involvement of multiple facial bones, it may be impossible, despite one's greatest efforts, to reestablish the normal facial contour. Functional difficulties may occur as the result of failure to bring the teeth into proper occlusion at the time that fractures involving the upper or lower jaw are treated. At times this may result from failure to detect a condylar fracture. With inadequate reduction of a maxillary and zygomatic fracture there may be impingement of the coronoid process of the mandible with resultant inability to open the mouth adequately or, on occasion, to close it properly. Diplopia due to nerve injury may be transitory or permanent. Diplopia also may result from inadequate reduction of the maxillozygomatic fractures with persistent falling of the infraorbital ridge and inward displacement of the body of the zygoma. This results in a falling of the orbit and tendency to inward rotation of the eye.

Nasal obstruction may occur even when the external nasal pyramid has been adequately reduced, if the nasal septum has not been properly reduced at the same time. On occasion, because the nasal septum is redundant or actually deviated prior to the injury, there may be considerable difficulty in restoring and maintaining the midline position of the nose after injury. Even if the nasal septum is restored to its midline position, it may later dislocate as a result of redundant cartilage and bone. I have made it a practice, when I suspect this problem to exist, to do an open reduction of the septum with adequate removal of cartilage and bone to eliminate overriding of fragments. Although not all complications of the surgical management of these injuries can be prevented, careful work and gentle handling of tissues can reduce them to a minimum.

Carcinoid Tumors Of The Rectum*

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MEDICINE remains interesting and fascinating because few, if any, subjects can ever be considered complete and put aside. New subjects and old are again and again scrutinized, re-appraised and reviewed by what we sometimes consider a disbeliever. In this manner, however, the unsolved problems are brought under new light, additional pertinent information is often revealed, aids to diagnosis are discovered, more specific treatment may result and an enlightened prognosis may all be the rewards.

Carcinoids of the intestinal tract, with particular reference to those in the rectum, are to be presented with hope of proving the value of such reviews.

In 1907 the term carcinoid was introduced. Obendorfer[11] used it to describe a carcinoma-like tumor which he found in the intestinal tract. He said that it was small, benign and non-metastasizing.

Origin and Distribution

We now know that it is widespread in the intestinal tract in spite of occurring more frequently in certain locations. It has demonstrated its malignant ability, and more recently has been proven, in some cases, to be functional, i.e., producing a substance which is accountable for a recognizable syndrome.

Gossett, Masson and Masson,[5] by use of ammoniacal silver nitrate stain, demonstrated the origin of the cell. It normally is found in the Kulchitsky cells of the crypts of Lieberkuhn which are widely distributed through the small intestine. The similarity of these cells to chromaffin tissue gave rise to the new term of argentaffin tumor cells, suggested the possibility of endocrine origin and led to the discovery of the carcinoid syndrome.

Carcinoids may appear anywhere in the intestinal tract from the esophagus to the rectum, but in the various collective reviews of Freund[4] and Richard A. MacDonald,[9] etc., 85% to 96% are found in the vicinity of the ileocaecal valve, appendix, caecum and terminal ileum. They comprise slightly more than 1% of all neoplatsic tumors of the gastro-intestinal tract and approximately 2% of all submucosal rectal nodules.

The appendiceal carcinoids seem to behave in a characteristic way. They do not spread beyond the mesoappendix and removal of the appendix and local nodes seems adequate treatment. Therefore, if the diagnosis is made postoperatively some feel that re-exploration is unnecessary. It is suggested, however, that all extra appendiceal carcinoids be considered as having malignant potential. This view is supported by the findings in MacDonald's[9] collected series of 356 cases of carcinoid tumors, in which malignancy was proven in 67% of these cases. The rectal carcinoids, however, have the lower incidence of 10%, according to Ilgenfritz and Matthews[6].

Histology and Incidence

Histologically the tumor cells are fairly constant in size and are typically epithelial, cuboidal or low columnar. As previously related, the cytoplasmic granules have silver-reducing properties. The decision as to whether the lesion is benign or malignant has something to do with its anatomical location, as previously in-

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ferred. It may be difficult, even microscopically, to make such a differentiation unless the classical signs of malignancy, namely, invasion into surrounding tissues, clinical evidence of distant spread or the carcinoid syndrome, are present.

The first case of carcinoid of the rectum to appear in the American literature was reported by Brunschwig[2] in 1933. Nine years later Stout[13] found an additional 6 cases in the entire medical literature. From 1942 to '51 an additional 66 cases were reported (Freund)[4]. Then, in the period from June, '51 till '57 (Freund)[4] over 200 cases were added. This obvious increasing incidence, I believe, is due in great part to the profession's interest in something new and its alertness to search out its various characteristics. Jackman[7] attributed the apparent increase to an awareness of rectal mucosal lesions resulting from the ease of rectal and proctoscopic examinations and the almost routine inclusion of this procedure as a part of most general examinations. In Jackman's[7] review he divided the submucosal rectal nodules into 4 categories: 1) benign, 2) inflammatory, 3) chemical and 4) malignant. Most of these submucosal rectal nodules were chemical in origin, i.e., lipoid granuloma attributed to injection therapy. A definite diagnosis is made only after microscopic examination. Benign lesions are variable but usually easily diagnosed; inflammatory lesions are almost invariably self-evident; the malignant lesions are usually leiomyosarcomas, lymphosarcomas or lymphomas. The gross carcinoid usually appears as a pale yellow or grayish tan submucosal lesion, which may be found on all walls from the ano-cutaneous junction proximalward for 24 cms. They are usually small, varying from 0.2 to 2 cms. in diameter.

Diagnosis and Treatment

The symptoms usually do not appear until malignant activation has occurred. Being a submucosal tumor the overlying mucosa ulcerates and initiates the chief complaint of melena, diarrhea, or rectal discomfort. If the lesion spreads by its customary routes, local extension, into the lymph nodes, along the nerve sheaths or by the blood stream, other symptoms appear from the metastases or from the carcinoid syndrome.

There has been some attempt to correlate the treatment with the size of the tumor. It is thought that the submucosal lesions less than 2 cms. in diameter may be removed with the biopsy forceps or excised and then fulgurated. The ulcerated lesions suggest malignant change. Definite evidence of extension through the bowel, local fixation or intra-abdominal carcinoid masses require radical surgery. Irradiation therapy is ineffective in treating this tumor. Urinary determination of hydroxy-indoleacetic acid should be included in the post-operative evaluation.

Summary

1. Carcinoids of the rectum comprise 2% of all submucosal rectal nodules.
2. 10% are said to be malignant.
3. They may be found on the walls from the ano-cutaneous junction to 24 cms. within the lower bowel.
4. The frequent inclusion of proctoscopy in doing a general examination has led to a higher incidence of detection of this lesion.
5. The carcinoid syndrome is an interesting manifestation of a functioning malignant tumor.

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The Historical Background Of Medical Therapy In Essential Hypertension*

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BEFORE the time of Galen (131-201 A.D.) real studies on the circulation had not been made. In Egypt, anatomic descriptions of the heart and blood vessels recorded in the Smith Papyrus, as far back as 3000 B. C., were not too informative. The Chinese writings (1000 B. C.) are a peculiar melange of anatomy and mysticism. Later, the Greeks took over and Plato, Aristotle, Hippocrates and others made new descriptions from animal dissections, but their ideas about the circulation were remarkably erroneous.

Aristotle gets credit for naming the aorta, but he had no idea of its function. Herophilus (300 B. C.), at Alexandria, using a water clock, probably was the first to record a pulse count. The early Italians contributed little. Seneca (4 B. C. - 65 A. D.), describing his own disease, probably recorded the first description of angina pectoris with coronary insufficiency.

Rufus of Ephesus (98-117 A. D.) wrote several treatises on the pulse and, according to Dr. Emmett Horine, possibly described the carotid sinus reflex, but no one paid great attention to functions or the process of circulation until Galen. The latter was a profuse writer and covered the field of anatomy, experimental physiology and therapeutics. His ideas about blood flow were imaginative, such as pores in the interventricular septum. He inferred the presence of anastomoses between capillaries. He wrote sixteen essays on the pulse and showed that arteries contained blood and that the heart possessed motor power. However, he expounded his superstitions and unsupported facts with such force that these false ideas were a deterrent to further investigation for fifteen centuries.

The next milestone was that erected by William Harvey whose classic "De Motu Cordis," 1628, is familiar to all. By experimental vivisection largely, he proved that the heart was a muscular pump that projected the blood. He showed definitely that the heart sent the blood through the arteries and that it returned through the veins, clearing up misconceptions of many centuries.

First Blood Pressure Determination

Credit for the next milestone 105 years later goes to a servant of the Lord, not an M.D. The Rev. Stephen Hales was born in Kent, England, in 1677. At Cambridge he got his B. A. and Master degrees in quick order, the latter because of a great interest in natural science and chemistry. In 1710, he was made perpetual curate at a small town in Middlesex. His famous essay on "Hemostatics" was published in 1733. He must be given credit for being the first person to read blood pressure by any means, using an intra-arterial manometer, his subjects—horses. This manometer was a little unhandy, being nine feet high, and his horses were tied down, unanesthetized, of course, and struggling some, I imagine.

The first blood pressures on man by means of a mercury manometer, after the method of Hales, were done by a Frenchman, Poiseuille, who constructed a hemodynometer in 1828, with which he made many fundamental observations which were interesting but questionably accurate.

The next epochal contribution came from Carl Ludwig, regarded by his confreres as a

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genius. He made the first kymograph in 1847 as well as the first blood pump and Stromuhr, and perfused excised organs. Sir Lauder Brunton, an outstanding clinical investigator in England at the end of the nineteenth century and beginning of the twentieth century, said of Carl Ludwig: "To him more than anyone else since the time of Harvey do we owe our present knowledge of circulation."

The first accurate blood pressure estimations made on man were done in the year 1856, in France, by Faivre, being direct readings with a mercury manometer just 123 years after Stephen Hales had done this on horses.

In 1855 Vierordt, a German, estimated human blood pressure by counter-pressure, measuring how much pressure it would take to obliterate the pulse. This and several modifications with improvements became the popular way of estimating systolic pressure for many years.

In 1880 a German, Von Bosch, devised the first accurate method, obliterating the radial pulse by means of a ball filled with water and measuring the pressure in the ball when the pulse was obliterated. Potain improved this apparatus, using a ball filled with air attached to an aneroid manometer. The bulb was pressed down gradually over the radial artery until the palpating finger could no longer feel the beat. The pressure needed to obliterate the artery was read on the manometer as the systolic pressure.

Riva-Rocci Apparatus

In 1896 Riva-Rocci introduced an apparatus consisting of a rubber bag surrounded by a cuff of inelastic material, connected with a mercury manometer and a rubber bulb. Air was pumped in until the radial pulse disappeared and the systolic pressure was read when the pulse was felt again. Thus ended the search started by Stephen Hales 163 years previously. This apparatus was first introduced into America by Harvey Cushing in 1902.

In 1897 Hall and Barnard in England put out a similar apparatus using a pressure gauge in place of the mercury manometer. Well do I remember the first Riva-Rocci apparatus which my father had one of his patients bring back from Italy in the early years of this century. It was a great boon and did away with guessing the pressure, not a very accurate method in the most expert hands, where pulses were usually divided into hard and soft. Soon differences in determinations were found due to the fact that Riva-Rocci and Hill-Barnard cuffs were 5 cm. in width and on large arms gave false readings. The cuff was standardized with a width of 12 cms. where it has remained.

In 1906, Dr. T. C. Janeway in New York remarked:

"To those who have learned at first hand the almost insoluble nature of many of the clinical problems presented to us and who feel as I do the poverty of our diagnostic resources, the accurate measurement of blood pressure must prove a valuable addition to our methods of physical examinations."

In June of 1912 Dr. Janeway read a paper before the American Medical Association on the cause of death of 100 patients with high blood pressure. It was discussed by Dr. L. F. Barker, Professor of Medicine at Johns Hopkins, my old professor; also by Dr. L. F. Bishop, Sr., one of the early cardiac specialists in New York; by Dr. E. C. Cornwall of Brooklyn; Dr. M. H. Fussel of Philadelphia and Dr. Nathanial B. Potter of New York. Reviewing the discussions of these learned men forty-six years later, it is astounding to recognize how much more a fourth year medical student knows today than those great minds did at that time.

The auscultatory method of determining blood pressure was described by Korotkoff, a Russian, in 1905, and with it the means of determining diastolic pressure.

Impact of Goldblatt's Work

In 1941, I read a paper before the Southern Medical Society in this city in which I pointed out that hypertension was responsible for 15 per cent of all deaths past the age of 50, that heart failure, cerebral hemorrhage, coronary thrombosis and so-called Bright's disease accounted for over 500,000 deaths each year in the United States. That was four times more than cancer, 20 times that of diabetes and tuberculosis. Very little was being done about it. There was no planned attack such as had been made on pneumonia, tuberculosis or syphilis. Had it not been for the occasional investigator, hypertension would have gone on unmolested, claiming its toll, with the outlook worse than in carcinoma, where millions of dollars were being spent in research.

Too much credit cannot be heaped on Harry Goldblatt for dispelling this apparent lethargy on the part of the profession. In 1933, by means

of clamps on the renal arteries of dogs, he concluded that renal ischemia is probably the cause of this disease. Finally an experimental animal had been found that could be used for clinical, pathological, biochemical and therapeutic studies.

Attempts at classification followed. R. W. Scott, of Cleveland, divided clinical hypertension into two groups, renal and non-renal with many subdivisions. Irving Page, who was beginning to shine brightly in this field and whose investigations have continued since, in 1939 divided hypertension into renal, cerebral, cardiovascular, endocrine and that of unknown origin. In this latter group he placed essential and malignant hypertension.

Previously, in 1930, Soma Weiss, in an article "On the Development of the Clinical Concepts of Hypertension," had given credit to Frederique Mahomed of England who in 1874 described the "prealbuminuric stage" of kidney disease. He showed then that blood pressure may be elevated without renal pathology and deserves credit for the original idea of "essential hypertension." Today we look on essential hypertension as that condition of elevated blood pressure for which we can find no organic pathological changes to explain its presence.

Early Drug Therapy

The drugs that were used early in the treatment of hypertension need only be mentioned by name. As we recognize now, they were being used on a group of diseases and no one drug could cover the entire field. In the 1890's tincture of iron, preferably old tincture of iron, was said to reduce elevated pressure. A few of the others were used — potassium iodide, sweet spirits of nitre, sodium nitrite, nitroglycerine, Veratrum Viride and morphine at times. Nitroglycerine and the nitrites were to be used with great caution!

In 1903, Pauli first used potassium sulfocyanate in the treatment of hypertension. The first American report was made by Nichols in the *American Journal of Medical Science* in 1925. My father began using it here shortly afterwards. Nichols did not know the mode of action but described its toxicity and the fact that it was slowly excreted. For years it was regarded with distrust because of the severe and even fatal toxic reactions. An editorial in *The Journal of the American Medical Association* as late as June, 1940, said: "Because of dangerous possibilities from the use of the drug, its value seems more doubtful than ever."

Great credit goes to Dr. M. Herbert Barker, of Chicago, who, in 1936, reported 45 cases of hypertension treated with this drug. In that article in *The Journal of the American Medical Association* he advocated the determination of blood level of cyanates and described a method.

In 1940, Ravin greatly simplified the blood cyanate determination, making it a colorometric method, easily done in any laboratory. By 1941, in my practice I had used cyanates in at least 200 cases with no serious toxic effects. Many people got excellent results with blood levels of 3 mgs. %. Barker had advocated levels of from 6 to 12 mgs. %, but I preferred never to allow the level to get above 8 mgs. %. Drops in systolic pressure from 30 to 80 mms., and diastolic from 20 to 40 mms., were not uncommon. It was an extremely useful and interesting drug and was the only real tool that I feel was available from 1930 until Rauwolfia appeared on the horizon. Many patients were controlled for years with no change in the dose. A small amount of potassium iodide was added later to prevent "cabbage goitre" which cyanates produced at times. Occasionally the effect of the drug would wear out and at times patients would get tired of taking it and would stop it. When the pressure would become elevated again, occasionally, for some reason which I never understood, the drug would not have the same hypotensive effect.

Modern Drug Therapy

In 1949, Rustorn Vakil, of Bombay, reported in the *British Heart Journal* on the use of Rauwolfia Serpentina in hypertension. Robert Wilkins, of Boston, obtained some of the drug from a pharmaceutical house in Bombay and noted that a moderate reduction in blood pressure took place in 40 per cent of the cases of essential hypertension. He also recorded many of the unpleasant side effects of the drug. He was responsible for Ciba refining Rauwolfia and producing Reserpine. There is still some dispute as to whether the refined products and alkaloids have better therapeutic possibilities than the crude drug. Wilkins first

reported use of the drug in 1951. About the same time Hydralazine (Apresoline®), and ganglion blocking drugs and finally Chlorothiazide have been used.

The results in the treatment of hypertension in the last seven years have exceeded anything that has occurred previously. Lives will be prolonged. Those who have had hypertension who ran a steadily downward course that could not be stopped ten years ago have now a chance for control of the disease. This is really a golden age for therapy after all these years, and there may be better tools ahead.

Certainly we have progressed a great deal since 1892, sixty-six years ago, when A. Foxwell, M.A., M.D., F.R.C.P., wrote an article on arterial hypertension in *The Lancet*. The final paragraph goes like this:

"Grief kills, but so they say does sudden joy. Joy quickens and stimulates cardiac action. 'My heart leaps up when I behold a rainbow in the sky' says Wordsworth. But suppose there is no field on which this joyful heart can display itself; suppose the blood canals are blocked with high tension? What then? The bounding heart is unable to suffuse with joy the peripheries of the body, its glowing warmth recoils discomfited upon itself. It cannot leap up. A great nervous revulsion occurs and Death comes. This is how it is that to some a great joy brings a ruddy glow and a feeling of fullness of life but to others deathlike pallor and a sense of dread oppression."

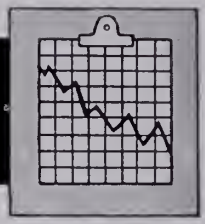
Be Sure to Read . . .

Symposium on "Carcinoma of the Lung"

in the November Journal



CASE DISCUSSIONS
From The
University of Louisville Hospitals



Multiple Primary Neoplasms

LOUISVILLE GENERAL HOSPITAL

Case History

M. M. (L.G.H.#92058), a 65 year old white woman, was first admitted to the hospital in June, 1933 with the chief complaint of metrorrhagia. Family history revealed that the patient's mother, two brothers, and one uncle had died of cancers of unknown sites. Physical examination revealed a mass in the uterus. After hysterectomy, this mass was found to be adenocarcinoma of the fundus of the uterus.

She enjoyed good health until November, 1949. At this time, she began to have pain in the left lower quadrant of the abdomen, constipation, and pink stained mucus in her stools. Roentgen study of the colon revealed an irregular filling defect at the junction of the descending and sigmoid colon. Surgical resection of this mass, which measured four centimeters in diameter, followed. Histologically, this was an adenocarcinoma, Grade II, primary in the colon.

Patient was readmitted to the hospital on February 3, 1950, because of pain in the left upper quadrant of the abdomen. Roentgen studies showed an obstructive lesion in the mid-portion of the transverse colon. At surgery an unsuspected lesion of the jejunum was also found about two inches distal to the ligament of Treitz along with a tumor of the mid-transverse colon. These two lesions were each found to be polypoid adenocarcinomas arising from separate sites.

In August, 1950, a non-tender, palpable mass in the right upper quadrant of the abdomen was found and she was admitted to the hospital for study. Thorotrast visualization of the liver showed a large filling defect in the right lobe of the liver. Laprotomy revealed a metastatic mucinous carcinoma of the liver which was resected followed by an uneventful recovery.

The patient did well until September 28, 1958, at which time a mass in the right lower quadrant of the abdomen was found. She was admitted to the hospital with the chief complaint of "I got another cancer." Roentgen study of the colon revealed a filling defect in the ascending colon. This too, after surgery proved to be an adenocarcinoma, Grade II. Patient was discharged from the hospital on November 7, 1958, feeling well.

Discussion

Cecil W. Ely, M.D., Department of Radiology, University of Louisville School of Medicine.

One of every 20 cancer patients will at a later date develop a second primary tumor.[7] This patient with five primary neoplasms is being presented to re-emphasize the importance of examination of cancer patients at regular intervals to detect the recurrence of the initial neoplasm as well as a search for a second primary at its earliest stage.

Since this patient has had only one known metastatic lesion she would not satisfy all the conditions proposed by Billroth in 1879.[8] He stated that each tumor must have an independent histological appearance, arise in different situations, and produce its own metastases before a diagnosis of multiple neoplasms could be made.

Excluding cancer of the skin, the chance of one person with one primary neoplasm developing five at later dates is at least one in fifteen hundred.[7] Warren found the incidence of multiple neoplasms to be 6.8% in a series of 2,829 cancer autopsies in 1933.[8] In this

series was one case of triple malignancy. In a series of 3,096 patients, Wallace found an incidence of 4.5% in 1957.[7] There were three patients in this series who developed five primary neoplasms. About 40% of the patients in Wallace's series developed all their tumors after the age of seventy. The average age interval between each successive tumor, when it could be determined, was 3.1 years.

Multiple neoplasms occur in certain organs with greater frequency than on the basis of chance alone. The skin, colon, and oral cavity are the most common sites in which multiple carcinomas may develop. Since a patient with a carcinoma of breast, testicle, or ovary has a greater chance of developing another cancer in the opposite organ than a patient of the same age group who has had no cancer, there may be an endocrine basis for the multiplicity of these tumors.[1]

Summary

A patient with five primary malignant tumors is presented with a review of the literature. At the present time the factors governing the incidence and spread of malignant disease are largely unknown. Multiple primary neoplasms may be explained by predisposition or susceptibility to cancer or by action of some factor favoring the development of cancer. Regular reexamination of known cancer patients is again emphasized because of the possibility of both recurrences and the development of new tumors.

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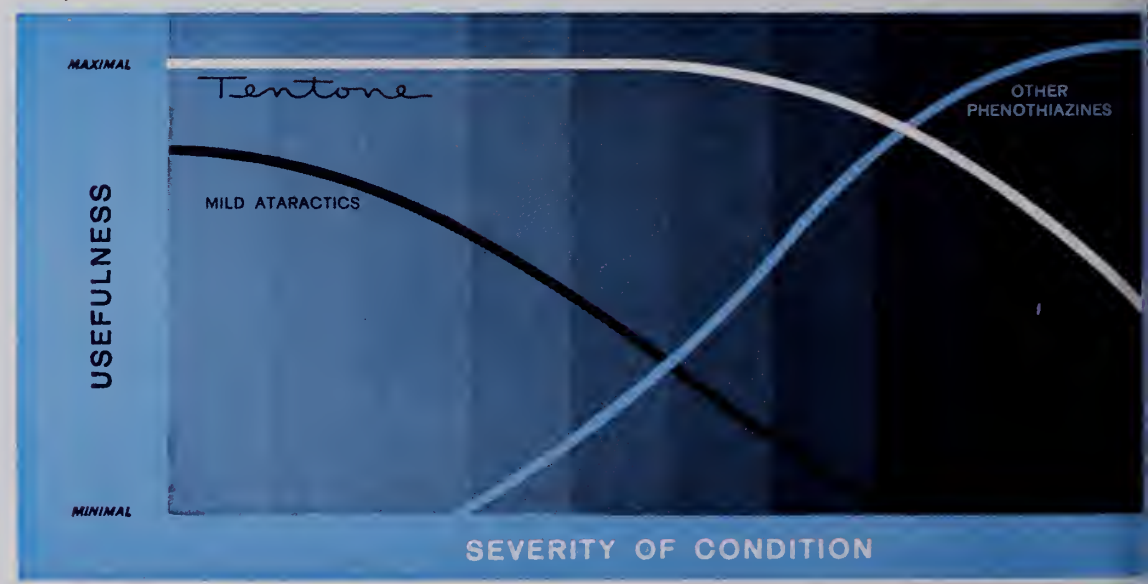
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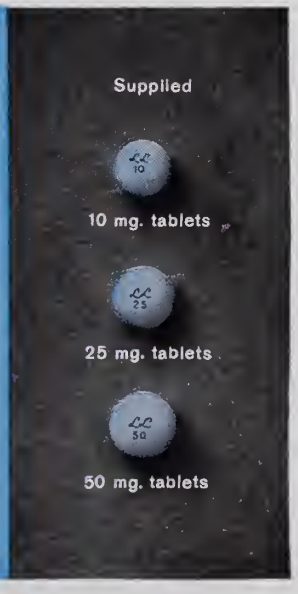
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SPECIAL ARTICLES

The Annual Diabetes Detection Drive—November, 1959

ROBERT J. HOFFMANN, M.D.*

South Fort Mitchell, Ky.

THE Annual Diabetes Detection Drive was initiated by the American Diabetes Association and is endorsed and sponsored by the Kentucky State Medical Association.

The primary objective of the drive is discovering unknown Diabetics. To further this cause, the aim of the Diabetic Committee is 100% County participation. It was felt that a more complete understanding of the American Diabetes Association and its aims might help to further this cause.

The ADA

The American Diabetes Association was founded in 1940. Active Membership is limited to physicians and some allied scientists.

The broad objective of the Association is to: "Promote among physicians and others the free exchange of knowledge of Diabetes Mellitus; to improve the standard of treatment; to promote research by individuals and institutions; to educate the public in the early recognition and treatment of Diabetes."

Three-point Program

The immediate program has 3 parts:

1) Increased post graduate education for the Medical Profession.
2) Expansion of Patient education—this includes *Forecast,* the magazine for Diabetics.
3) Intensification of Public Education and case-finding program, such as this drive.

The ADA is governed by a Board of Governors, whose majority must be Physicians.

Source of Funds

For 1958-1959 57% of the Association's Budget came from self-supporting projects, such as the magazine *Forecast.* The remaining 43% came from contributions by membership, foundations, civic organizations and others.

Use of Funds

Funds are annually audited by an accounting firm. For the fiscal year ending March 31, 1959:

Professional Education	31%
Patient Education	33%
Public Education and Case Finding	20%
Research	6%
General Administration and Depreciation	10%

Summary

The ADA is a Medical Organization, controlled by Doctors, with no public organized fund drive; whose main objective is control of Diabetes. Your Committee believes this drive warrants your whole hearted support.

Chairman of the KSMA Associate Committee on Diabetes.



The Vanishing Individual

TODAY we find ourselves as members of the most prosperous, growing and powerful country in the world. This has been achieved in less than 400 years by a group of people who were adventuresome and bold, filled with the desire for freedom of personal pursuit of any goal without external oppression. With dauntless courage these people assumed tremendous responsibility for themselves and their families and they proceeded to build a new country. Their offspring have followed along in expansion and preservation of freedom for all in the individual search for peace, prosperity and happiness. With hard work the search has been duly rewarded.

However, with a steadily increasing population, new problems have been encountered. There are in any community those who are medicaly indigent for one reason or another, and they are rightly cared for by the indigent's family and friends. When these are missing, the community as a group provides the necessities of life for those who are less fortunate. In any society these medical, social or economic indigents will exist and appropriate steps rightly should be taken for their care.

This basic responsibility can get out of hand though and the idea of individual dependence upon the group can grow to unwieldy proportions. It is, I suppose, one facet of human nature to seek out "bargains" or "something for nothing." Occasionally real bargains are found, but to get something for nothing seldom if ever really happens.

The freedom to work and the idea of the better, harder and more time spent at work yielding more remuneration is sound and logical. To work long and hard for little pay and with no consideration for "overtime" is unsound and soon the incentive of the individual disappears. Shortly thereafter the quality of his work declines too.

The organization of labor for the purpose of collective bargaining and the representation of the people in general in the form of our Senators and Representatives in State and Federal governments is excellent. More equitable relations between employer and employee have been accomplished and governmental responsibility has been shared with the individuals represented. What happens though if these basic ideas become exaggerated?

Is it proper to demand the same pay for less work, e. g. 40 hour a week pay for a 30-35 hour work week? How long would employers actually be able to stay in business on this basis? To be paid for protecting one's own rights by accepting the responsibility of representing our country when at war, e. g. Veterans Bonuses? To demand the same price for over-produced products regardless of the public need and expect the public to pay for it? To expect other people, as represented by the government, to pay for our own and our children's education? To wish our own parents and relatives off on other people, as represented by the State, for their care when they become too feeble to care for themselves? Is it proper for those who normally earn enough money to provide for their own retirement to expect contributions from others when retirement comes?

Some of these things we ask for on our own and others tend to be wished upon us as citizens by well meaning labor leaders and congressmen. What is the final outcome of this concept? Basically, what we as individuals are doing is asking others (the total group) to share our own personal responsibilities. The more responsibility we give up to others, the less we as individuals will have.

Opinions expressed in contributions to The Journal are those of the writers and do not necessarily reflect the views of the Kentucky State Medical Association.

To have responsibility for solving our problems requires having the right to decide how these problems will be solved. Therefore, the more we ask of the government and the more we blithely acept from it the more rights the government must have to meet these problems. The more we as individuals ask of the group, the more dependent we as individuals will become. Carried farther, the more responsibility we share with the group the less we will have as individuals. This requires the giving of more rights of decision to the group and retaining less rights of decision as individuals. This is to gradually lose the individual and his responsibilities and to reduce him to being nothing more than a member of the larger group, employed by and dependent upon the government for the satisfaction of his needs and desires.

I am not here to say whether this is right or wrong, but to point out what is obviously happening and to ask again: Is this what a free nation made by individuals really wants?

Peter A. Overstreet, M.D.

The Approach To Treatment In Anemia

THE 1959 edition of *The Physician's Desk Reference* lists over 250 different anti-anemia preparations, each of which is purported to have specific and significant advantages in the management of the anemic state. Each day the physician's desk is piled high with elaborately illustrated literature outlining special benefits which may be obtained from a particular product. The vast majority of these products are multi-vitamin preparations and usually contain varying amounts of all the known vitamins including B_6 and B_{12}, intrinsic factor preparations, folic acid, iron, copper, cobalt and a variety of other trace metals plus substances to enhance absorption. We are left with the impression that any treatable anemia should be able to respond to one of these combinations and that our guiding principle should be to use a preparation which is certain to contain any element that might possibly be of value.

These principles, however, are not in accord with accepted medical practice in regard to treatment of other organic disease. With the increasing availability of potent and effective drugs, the use of a single therapeutic agent, whenever possible, is urged by all authorities in managing a variety of conditions from bacterial infection to endocrine deficiencies. These teachers uniformly agree that multiple drugs should be used only when specific indications are present for each one of them. This is of particular importance since many of our wonderfully effective drugs have additional unfortunate and dangerous side effects. The use of drugs in combination compounds the dangers and makes it difficult, if not impossible, to separate the good from the bad effects of the agents employed. It is then readily apparent that correct diagnosis and specific therapy is a prime prerequisite for intelligent management of most organic disease.

These principles, which are accepted without question by the great majority of the practicing physicians in respect to the management of most illnesses, are not always followed in treating anemia. The numerous capsules of various sizes, shapes and colors containing all the known, and many unknown, hematenic substances which are produced in volume by the drug firms and presumably administered in quantity by physicians is in itself significant evidence of this fact.

Are there exceptions to the management of anemia which place it in a special category? Or, should we more closely scrutinize these divergent principles to see if there are significant disadvantages to the "shot gun" treatment of anemia as have been demonstrated in the management of other conditions?

Mechanics of Anemia

There are only three processes by which an individual becomes anemic. Anemia may be the result of decreased production of red cells. It may occur if there is destruction of red cells, or finally if there is blood loss from the vascular bed.

A deficiency of an essential material required for production of red cells is one cause for decreased production of erythrocytes, but it is only in situations where such a deficiency does exist that any benefit can be had from the use of agents such as iron, B_{12}, folic acid or very rarely pyridoxine, ascorbic acid and crude liver materials. These deficiency anemias occupy

only a small segment of the anemias seen in clinical practice and, therefore, these substances are useful in only a fraction of the patients which are seen with anemia. There is no evidence that the use of these substances is of any benefit in non-deficiency anemias.

Diagnosis of Anemia

As in the diagnosis of any condition, it is of primary importance to determine whether or not a significant abnormality is present in the patient suspected of having anemia. The persistent popularity of the multiple anti-anemic preparations is based in large part on persistence of popularity of inaccurate methods of diagnosis of the anemic state. We would not consider gauging a febrile response using a thermometer which would vary several degrees in the reading at the same temperature and yet the red blood count remains the most popular guide to the presence of anemia and to the response of anemia to treatment. The known range of error of this method in the best hands (using two pipets) is 11% and it has been repeatedly demonstrated that the error in the average laboratory is as high as 22%. Such variation can easily make normal patients appear anemic or may indicate a response to treatment without any change in the actual body red cell mass. It is usually this laboratory anemia which appears responsive to emperic "shot gun" therapy since there is seldom enough medication contained in the multiple drug combinations to treat a specific deficiency if one does exist.

If an anemia is suspected on the basis of a low red blood cell count the presence of a significant anemia should be confirmed by the infinitely more accurate methods of a packed cell volume (hematocrit) and a photo-electric determination of the hemoglobin by the cyanmethemoglobin method. If this is done, much of the credit for an apparent response, based on laboratory variation, will be taken from the multiple hematenic preparations. A better approach, of course, is the substitution of the simpler, faster and more accurate hemoglobin and packed cell volume determinations for the red cell count. Most of the leading medical centers have, in fact, completely discarded the laborious and inaccurate manual red cell count for determination of anemia.

Contraindications To Shot Gun Therapy

Although it might be agreed that the "shot gun" preparations are useless in the great majority of anemias, perhaps their use should not be criticized too strongly unless there are contraindications to their use. There are, in fact, significant reasons why many patients should not receive these preparations.

First, the use of these panacea combinations may be substituted for proper diagnostic study. A significant and confirmed anemia is an important sign of an underlying abnormality in body physiology which deserves thorough investigation. These preparations are used most commonly in situations where the physician does not have a clear understanding of the mechanisms of the anemia.

Second, the use of these preparations may mask an important disease process. The substitution of emperic therapeutic trial for specific investigation may allow progression of a malignant disease beyond the point of curability. This has happened all too often with malignancies of the gastrointestinal tract in which a small amount of blood is being lost. It is particularly tragic if these anemias which may produce iron deficiency do respond to the iron contained in the medications since investigation is further deferred.

Third, these products not uncommonly are responsible for allowing chronic under-treatment of patients who have unsuspected pernicious anemia. The diagnosis of pernicious anemia has become very difficult because of the widespread use of compounds containing intrinsic factor, Vitamin B_{12} and folic acid. These preparations may give a partial hematological remission but allow continuous progress of the associated neurological abnormalities to the point of permanent crippling. It would be preferable to allow these patients to enter a complete and full relapse at which time the diagnosis can be made on the basis of a characteristic clinical picture. If a secure diagnosis is made, a program of sufficient lifetime therapy can be instituted. It is indeed unfortunate that this disease which is certainly one of the most satisfactorily treated diseases in the whole realm of medicine is now frequently undiagnosed and under-treated.

Fourth, the use of products containing iron for chronic non-iron deficient anemias may lead to secondary hemochromatosis. In these patients there is a breakdown of the usual block that prevents excess oral iron absorption. It has been recently shown that patients with chronic anemias that are not due to iron de-

ficiency have increased iron absorption creating excessive body stores beyond physiological limits. For this reason, even oral iron preparations should be avoided in anemias not associated with iron deficiency in the same manner that excessive transfusion is avoided. Certainly parenteral iron therapy should never be given unless a specific indication exists and there is secure evidence that the anemia is on the basis of iron deficit.

Fifth, the use of drugs in combination prevents the proper evaluation of response to treatment in situations where a deficiency is thought to exist. A specific response to a single agent provides simple and important confirmatory evidence of the correctness of diagnosis in deficiency states whereas the use of even two drugs in combination will prevent the physician from knowing which drug is the active one. If the expected response to a specific agent does not occur, then a new course of investigation should be undertaken.

Sixth, the use of multiple compound preparations adds unnecessary expense to patient care. There is an increasing awareness, both by physician and the general public, of the rapidly rising cost of medical care. In many instances, this increase has been accompanied by beneficial effects to fully justify it. However, the use of compounds containing 5 to 25 different substances is expensive and their widespread use is responsible for a significant section of the total outlay for drugs by the American public. If they are not indicated, certainly this is one place where spiraling medical costs can be combatted with no loss to the individual patient or to the physician.

Treatment of Deficiency Anemias

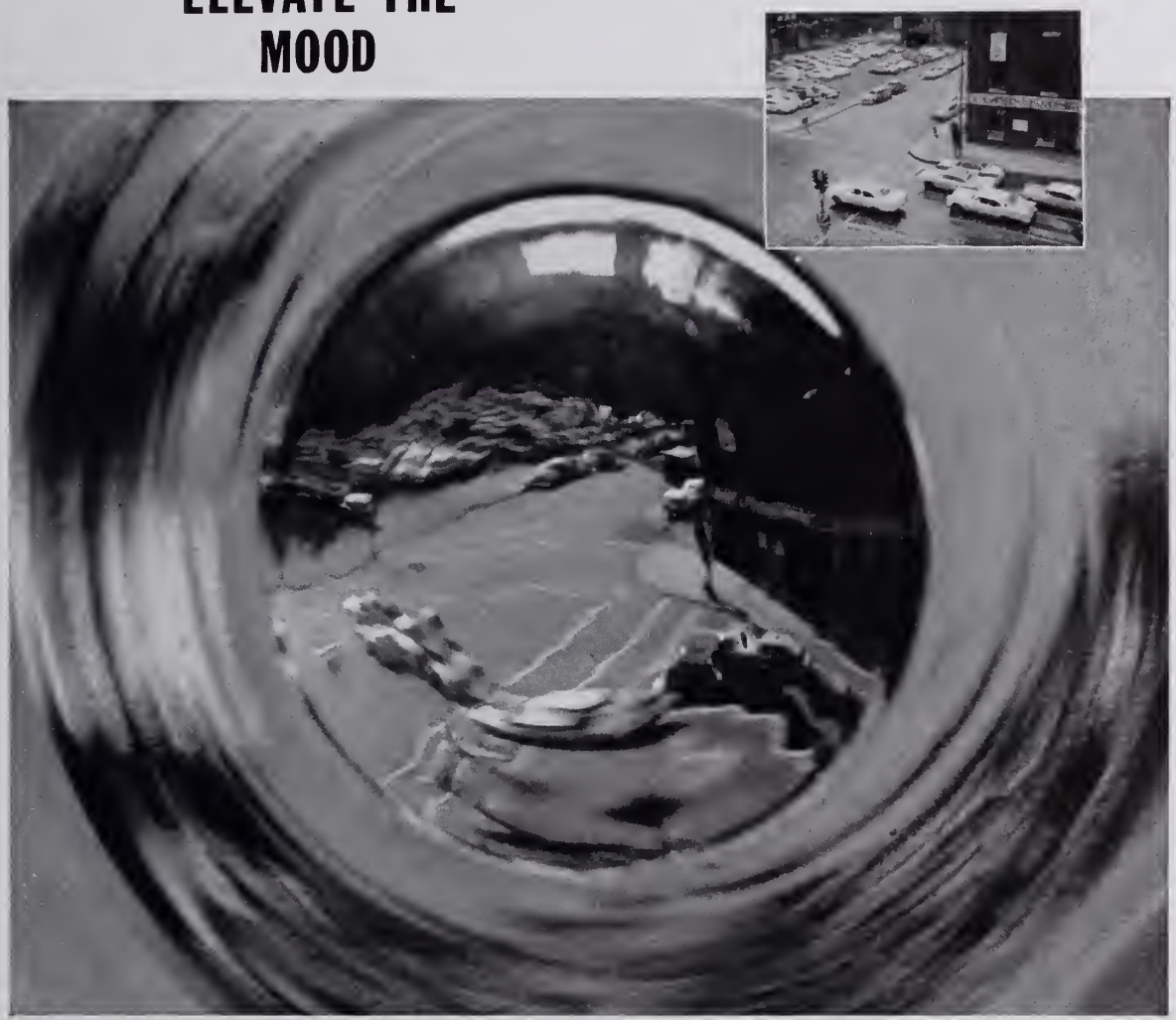
The proper treatment of deficiency anemias is relatively inexpensive. Ferrous sulfate remains the most satisfactory agent for iron deficient anemia and is well tolerated by most patients. Double blind studies have shown that the occurrence of gastrointestinal disturbance is largely psychic in origin and occurred almost as frequently after placebo administration as after the ferrous sulfate. Monthly injection of crystalline Vitamin B_{12} is by far the most economical and satisfactory method of maintaining pernicious anemia patients in complete and satisfactory remission. Folic acid deficiency rarely occurs except in childhood, pregnancy and malabsorption syndromes. When it does occur, it should be treated with 5 to 15 milligrams per day rather than the 0.5 to 1.5 milligrams included in most preparations as the minimum daily requirements. The same principles hold true for the rare patient that may appear to have a deficiency of ascorbic acid or pyridoxine.

Summary

In summary, a significant anemia is an important sign post of disease which deserves the same program of investigation, diagnosis and specific treatment as is accorded other symptoms and signs suggesting altered body function. There are no indications for the use of "shot gun" multiple substance antianemic preparations, and there are valid reasons why such combinations should not be used. The use of these preparations should be discouraged.

Ellis A. Fuller, M.D.

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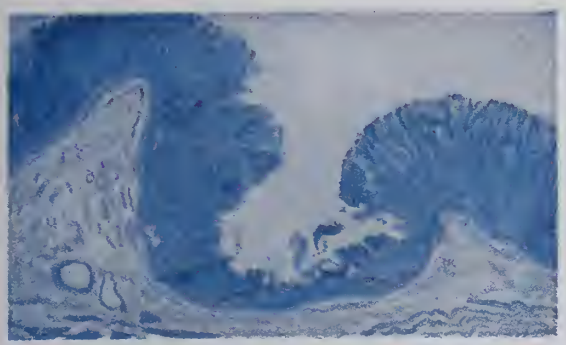
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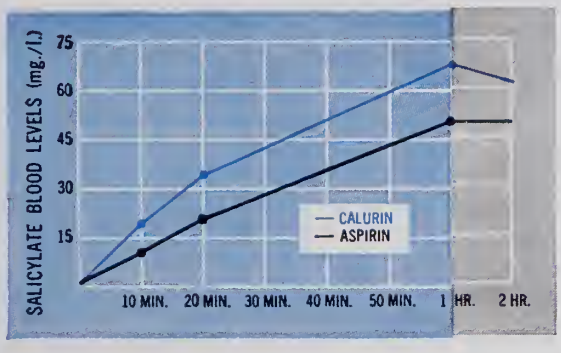
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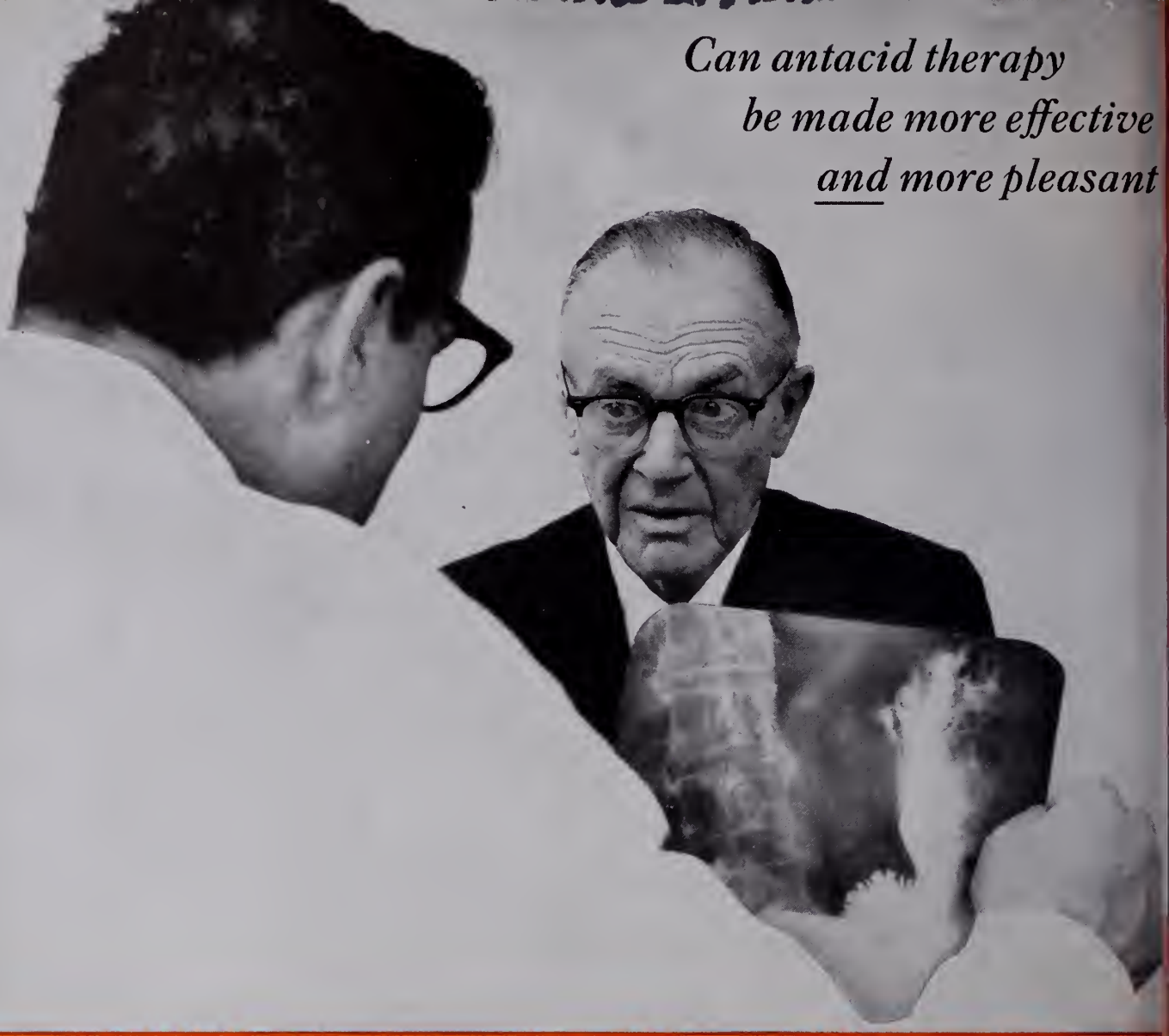
Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

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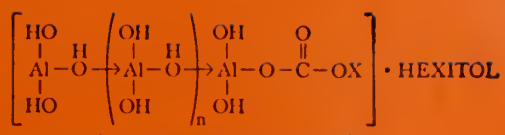
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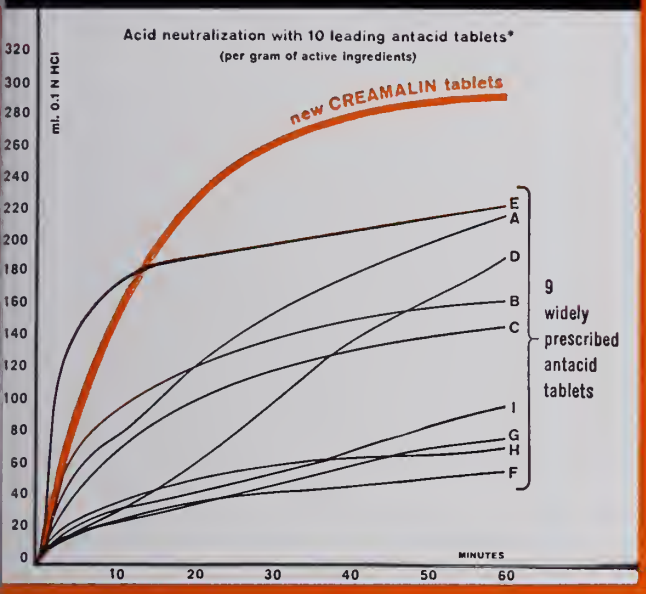
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n is at least 1 and averages less than 6. X is a cation.

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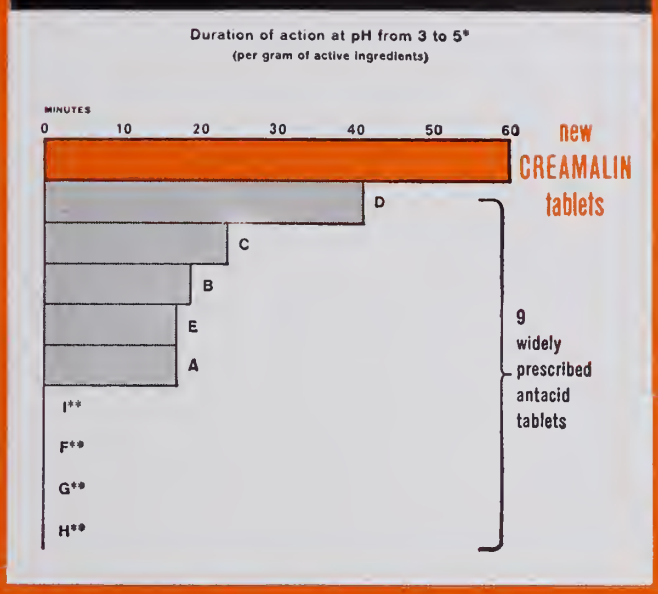
Quicker Relief • Greater Relief



*Tablets were powdered and suspended in distilled water in a constant temperature container (37° C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

CREAMALIN NEUTRALIZES *MORE* ACID *LONGER*

More Lasting Relief



*Hinkel, E. T., Jr., Fisher, and Tanner, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
**pH stayed below 3.





No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

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Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

Supplied: Bottles of 50, 100, 200 and 1000.

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For those patients who complain

carries your patients through the middle of the night





Each Nebralin timed-release tablet contains:

Dorsital* ..... 90 mg.
Warning: May be habit forming

Mephenesin ....425 mg.

*Dorsey brand of pentobarbital

CAUTION: Federal law prohibits dispensing without prescription

Dosage: One or two tablets ½ hour before retiring.

about waking up at 2 A.M.



nebralin®

timed-release tablet

timed-release action for a full night's sleep

NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2, 3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

1 Schlesinger, E. B.: Tr. New York Acad. Sc. 2:6, (Nov.) 1948.
2 Richards, R. K., and Taylor, J. D.: Anesthesiology 17:414, 1956.
3 Shideman, F. E.: Postgrad. Med. 24:207, 1958.
4 Berger, F.: Pharmacol. Rev. 1:243, 1949.

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Here's the Answer to the CPC

Pulmonary Alveolar Proteinosis Treated with Varidase®*

DANIEL E. MAHAFFEY, M.D., EVERETT N. RUSH, M.D., and JOHN D. ALLEN, *M.D.*#

Louisville, Ky.

IN JUNE 1958, Rosen, Castleman and Liebow reported a previously undescribed pulmonary disorder to which they applied the descriptive term, "pulmonary alveolar proteinosis." The disease is characterized by the intra-alveolar deposition of a granular "proteinaceous" material apparently formed by the shedding and disintegration of alveolar septal cells without any significant inflammatory reaction. It is manifested clinically by varying degrees of respiratory distress from mild cough to dyspnea, cyanosis and even death as a result of pulmonary insufficiency. X-rays of the chest reveal a fine, diffuse, perihilar, radiating, feathery or vaguely nodular, soft density, resembling in its "butterfly" distribution the pattern seen in severe pulmonary edema. This is in striking contrast to paucity of physical findings observed early in the course of the disease. To date there have been approximately fifty recognized cases.[1,2,3,4,5] Of the original twenty-seven cases reported, nine have already died.[1,3] The etiology is unknown and there has been no effective treatment demonstrated up to the present time. This is the report of a case treated with Varidase Topical® administered by nebulization in conjunction with intermittent positive pressure breathing.

Case Report[7]

A 36-year-old married white para ii, gravida i office worker was admitted to the Kentucky Baptist Hospital on February 11, 1959, complaining of dyspnea on exertion and a cough productive of mucoid sputum. These symptoms had been recurrent over a five-year period, sometimes accompanied by a febrile reaction, and had been interpreted as episodes of pneumonitis and treated as such. X-rays of the chest on four separate occasions in the last three years revealed bilateral patchy infiltrates, most marked in the lower lung fields. Physical examination revealed a moderately obese, white female appearing somewhat older than her stated age, subacutely ill and coughing intermittently during the examination. She appeared somewhat plethoric and there was mild cyanosis of the nail beds. Her temperature was 98.6°F, pulse 96, respirations 22 and blood pressure 150/100. Auscultation of the chest revealed scattered rales throughout both lung fields, most marked over the bases. The remainder of the physical examination was within normal limits. Laboratory findings were: RBC 5,900,000, Hgb 17.3 gms., PCV 52%, WBC 12,800, Neutrophiles 72%, Eosinophiles 1%, Lymphocytes 26%, Monocytes 1%, Urinalysis normal, ESR 13 mm. in one hour, Serum Calcium 9.8 mgm%*, NPN 33 mgm%, Serum Albumin 4.2 gms.,



Figure 1. First film taken in March 1956, showing cottony, patchy, soft densities more marked about hili and bases bilaterally. All subsequent films prior to initiation of Varidase ® therapy are essentially similar.

and Globulin 2.0, A/G 2.1/1, VDRL negative. A streptococcus pyogenes was cultured from the sputum. X-rays of the chest revealed bilateral patchy infiltrates throughout the lower two-thirds of the lung fields, a little more marked on the right side.

Hospital Course: On February 16, 1959, the right scalene fat pad was excised under local anesthesia and submitted for biopsy. The specimen showed only normal lymph nodes. She was discharged the same day. She was readmitted in five days for lung biopsy. She was operated upon on February 23, 1959,

---

* *This case was the subject of a clinicopathologic conference presented at the annual meeting of the Kentucky State Medical Association in Louisville on September 23, 1959, and was discussed by Carlos A. Fish, M.D., Louisville, Robert H. Ritterhoff, M.D., Covington, and James B. Douglas, M.D., Louisville.*

From the Departments of Surgery, General Practice and Pathology, Kentucky Baptist Hospital, Louisville, Ky.

* *Serum Calcium was incorrectly reported in the Protocol of the Clinicopathologic Conference[7] as 9.8 mEq/l.*

at which time sections of the right upper, middle and lower lobes were removed for biopsy. Grossly, the lung appeared to exhibit varying degrees of consolidation most marked in the lower lobe. The lung had a granular consistency without discrete nodules. The visceral pleura appeared somewhat thickened. There was no free fluid nor were there any adhesions. There was no significant hilar adenopathy. Water-seal drainage was afforded for the first twenty-four hours. The patient tolerated the procedure quite well, was out of bed on the second postoperative day and had an uneventful postoperative course. Sections of the lung showed the characteristic lesions of pulmonary alveolar proteinosis.[1] Based on the assumption that the intra-alveolar substance was in fact "proteinaceous," and inasmuch as no effective therapy has been described, we elected to use a solution of Topical Varidase® in nebulized form and delivered to the alveoli by intermittent positive



Figure 2. Characteristic microscopic appearance of alveolar proteinosis, showing normal alveolar walls, alveoli solidly filled with eosinophilic and PAS positive, finely and coarsely granular and floccular "proteinaceous" material and degenerating granular septal cells without inflamation, fibrosis or tissue necrosis.

pressure breathing (Bennett Machine*). Therapy was begun on the sixth postoperative day and continued at approximately biweekly intervals for the next three months. With each treatment approximately 25,000 units of streptokinase and 6,250 units of streptodornase in 2.5 ml. of normal saline was used. She showed the usual side-effects of Varidase® therapy, i.e., chilly sensations, fever, malaise and generalized aching. These symptoms were partially controlled by the use of aspirin, both before and after each treatment. In addition to the Varidase® therapy she has continued to use oral iodides as Organidin® 10 minims t.i.d. By the end of the third month of treatment the patient had shown such a

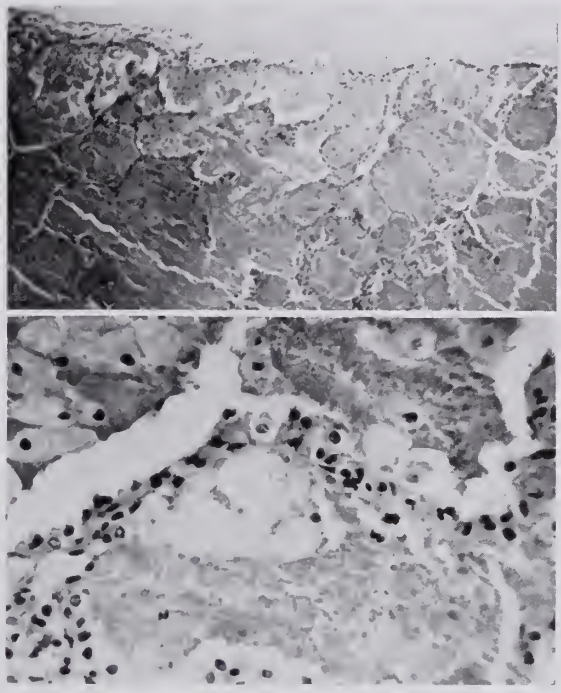


Figure 3. Film taken 9-28-59, showing complete clearing of pulmonary densities which was associated with complete clinical remission.

marked degree of clinical improvement that it became difficult to secure her cooperation in further treatments. She took a single treatment in the month of June and has taken only two or three Varidase® treatments in each of the succeeding three months. She no longer complains of any dyspnea or cough and is clinically well. There has been a decline in her compensatory erythrocytosis from 5,900,000 to 4,910,000 and in her hemoglobin from 17.3 gms. to 14.2 gms. A chest x-ray made on July 1, 1959, four months after establishing the diagnosis and institution of the Varidase® therapy revealed marked clearing of the previously observed infiltrates. Her chest had cleared completely both by x-ray and physical examination.

Discussion

It would be both presumptuous as well as premature to make any dogmatic statement on the basis of a single case observed for such a brief period. However, the result of the therapy was so encouraging that we felt that it should be recorded in order that its value might be assessed further by others. Although the intra-alveolar material has been incompletely identified, inasmuch as it has been shown to contain some mucin along with lipoid material, amino acids and nucleic acids,[3] it seemed logical that in the absence of any naturally occurring enzymes from the breakdown of polymorphonuclear leukocytes an attempt to liquefy the proteinaceous material by use of inhalation of a proteolytic enzyme might prove efficacious. Accordingly we resorted to the use of Varidase® knowing that the streptodornase

(Continued on page 1254)

* *Manufactured by Bennett Respiration Products, Inc., 2230 South Barrington Avenue, Los Angeles 64, Calif.*

Open To All Physicians . . .



1959 Symposia

OKLAHOMA CITY, OKLAHOMA
Fri., Oct. 2, 1959, The Skirvin Hotel

BIRMINGHAM, ALABAMA
Sun., Oct. 11, 1959, The Dinkler-Tutwiler Hotel

TACOMA, WASHINGTON
Wed., Oct. 14, 1959, The Hotel Winthrop

TRAVERSE CITY, MICHIGAN
Fri., Oct. 23, 1959, The Park Place Hotel

LUBBOCK, TEXAS
Sat., Oct. 31, 1959, The Lubbock Country Club

ST. CHARLES, ILLINOIS
Wed., Nov. 4, 1959, The St. Charles Country Club

DALLAS, TEXAS
Fri., Nov. 6, 1959, The Hilton Hotel

WICHITA, KANSAS
Sat., Nov. 7, 1959, The Hotel Broadview

SCHENECTADY, NEW YORK
Thurs., Nov. 12, 1959, The Mohawk Golf Club

CORPUS CHRISTI, TEXAS
Fri., Nov. 13, 1959, The Robert Driscoll Hotel

RIVERSIDE, CALIFORNIA
Sun., Nov. 15, 1959, The Mission Inn

SANTA BARBARA, CALIFORNIA
Wed., Nov. 18, 1959, The Santa Barbara Biltmore

MOLINE, ILLINOIS
Wed., Dec. 2, 1959, The LeClaire Hotel

1960 Symposia (incomplete schedule)

DENVER, COLORADO
Sun., Jan. 10, 1960, The Cosmopolitan Hotel

AUSTIN, TEXAS
Fri., Jan. 15, 1960, The Commodore Perry

POCATELLO, IDAHO
Sat., April 2, 1960, The Bannock Hotel

MOORHEAD, MINNESOTA
Sat., April 9, 1960, The Frederick Martin Hotel

SALT LAKE CITY, UTAH
Fri., April 22, 1960, Hotel Utah

ST. LOUIS, MISSOURI
Sun., May 1, 1960, Chase-Park Plaza

SANTA ROSA, CALIFORNIA
Fri., Sept. 16, 1960, The Flamingo Hotel

GREAT FALLS, MONTANA
Sat., Oct. 22, 1960, The Rainbow Hotel

CHARLESTON, WEST VIRGINIA
Sun., Oct. 30, 1960, The Daniel Boone Hotel

In cooperation with medical organizations throughout the United States, Lederle continues to offer aid to post-graduate medical education through its Symposium program. Upon completion of the schedule above the number of Symposia presented will exceed 200 since the first meeting, sponsored by the Knoxville (Tenn.) Academy of Medicine eight years ago. Each meeting presents prominent authorities discussing important advances in clinical medicine and surgery. Activities are also planned for physicians' wives.

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Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ¼

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Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ½

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Caffeine ..... gr. ½
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dysmenorrhea
neuralgia
minor trauma
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minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis/bursitis

relief of pain
of all degrees of
severity up to
that which
requires morphine

AND IN
fevers
dry,
unproductive coughs



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ORGANIZATION SECTION

Members Urged to Cooperate During Diabetes Week

"Be alert! Be sure! Be tested!"—that's the slogan of the 1959 Diabetes Detection Drive in Kentucky sponsored by the KSMA in cooperation with the American Diabetes Association.

Posters carrying the slogan and press and radio releases stressing the importance of testing in detecting diabetes are being distributed by the KSMA Associate Committee on Diabetes headed by Robert J. Hoffmann, M.D., South Fort Mitchell.

During Diabetes Week—November 15 to 21—the committee hopes to inform the general public about diabetes, to discover as many hidden diabetics as possible and bring them under proper treatment, and to disseminate knowledge to diabetics that will help them to keep well, useful, and happy lives.

All KSMA members are urged to cooperate with their county chairmen by giving free urine sugar tests during the week and reporting the results to the chairmen.

According to the ADA it is estimated that there are more than 1,000,000 diabetics in the U.S. under treatment—or about one in every 160 Americans. In addition, there are nearly as many unknown diabetics—people who have diabetes but do not know it. Thus, approximately one person in every 80 has diabetes.

Last year 180 newly proved diabetics were discovered and 90,598 free tests were made in Kentucky. The committee is striving for even greater physician participation in the 1959 drive.

An article on the Diabetes Detection Drive by Doctor Hoffmann appears on page 1218 of this issue.

Rural Health Conference Set for Nov. 5 in Bowling Green

"Horizons in Rural Health" will be the theme of Kentucky's seventh annual Rural Health Conference at the Olde Fort Restaurant in Bowling Green on November 5.

Purpose of the Conference, according to Mitchell B. Denham, M.D., Maysville, chairman of the Rural Health Council, is to stress the need for better health care for rural Kentuckians.

This marks the first time the Conference has been held outside of Louisville. Residents from throughout the State are invited to attend, and special promotions are being conducted to promote attendance in fourteen counties surrounding Warren County.

The Rural Health Council is made up of about 20 civic organizations, including the KSMA, which have a mutual interest in improving the health care offered our rural citizens.

The day-long conference is scheduled to start with registration at 9:15 a.m. and will adjourn at 3:30 p.m.

Following is the Conference program:

Morning Session
John Koon, Executive Secretary, Kentucky Farm Bureau, presiding

9:15 Registration

9:35 Comments and Announcements, John Koon
Invocation, Thompson R. Bryant, Assoc. Director, Emeritus, Extension Service, Lexington, Ky.

9:45 Official Welcome
Burl St. Clair, President, Kentucky Farm Bureau Federation, Falls of Rough

10:00 Panel—"Diseases Transmitted from Animal to Man"
Daryl P. Harvey, M.D., Glasgow, moderator
Charles L. Taylor, retired agriculture teacher, Bowling Green, Ky.
William T. Roark, Young Farmer of the Year, Franklin, Ky.
H. A. Gray, D.V. M., Bowling Green, Ky.
Mrs. James Davenport, Farmer's Wife, Bowling Green, Ky.

11:00 Break

11:15 "Medical Care for Kentucky's Indigent"
Gaithel Simpson, M.D., Greenville

11:35 Question and Answer Period

Luncheon Session
E. M. Josey, secretary, Kentucky Pharmaceutical Assoc., presiding

12:15 Address, Mr. Kelly Thompson, President, Western Kentucky State Teachers College, Bowling Green

1:45 "Nursing Home for the Aged"
Paul A. Hackney, director of Hospitals and Medical Service, Kentucky State Department of Health
Mrs. Jamie E. Miller, L.P.N., Lexington

2:30 Panel—"Progress in Rural Area Developments"
W. W. Hourigan, Area Extension Agent, University of Ky., moderator, Bowling Green
Jim C. Spradlin, Morgantown, "How Butler County Got A New Health Center"
Mrs. Francis Rice, Adairville, "How We Have Progressed in Logan County"

3:15 Farewell Address
Mitchell B. Denham, M.D., Maysville

AMA to Hold Clinical Sessions in Dallas, Dec. 1-4

About 3,500 physicians are expected to attend the 13th Clinical Meeting of the American Medical Association in Dallas, Texas, on December 1-4, according to Everett G. Fox, M.D., Dallas, general chairman of the meeting.

Planned by the AMA in cooperation with Dallas physicians, the scientific program of lectures, symposiums, medical motion pictures, color television, and nearly 100 scientific exhibits will be held in Dallas Memorial Auditorium. There will also be more than 250 technical exhibits on display.

Among outstanding speakers scheduled during the scientific sessions are Hubertus Strughold, professor of space medicine at the School of Aviation Medicine, Randolph Air Force Base, Texas, often called the "father of space medicine," and Michael E. DeBakey, M.D., Houston, winner of the 1959 AMA Distinguished Service Award.

The Auditorium will also house the "world's largest health fair" sponsored by the Dallas County Medical Society in conjunction with the AMA. The fair will run from November 27 to December 7 and will be open to the public.

An adjunct to the meeting will be a national conference on the medical aspects of sports which will be held on Monday, November 30—the day before the meeting begins.

During the meeting the AMA House of Delegates, meeting at the Adolphus Hotel, will choose the General Practitioner of the Year. This award is given annually to an outstanding American doctor for his medical and civic contributions to his community.

This is the second time the AMA has held a meeting in Dallas. In 1926 an annual meeting was held there.

Carcinoma of Lung is Subject of Symposium Issue

"Carcinoma of the Lung" is the topic of the Journal's second annual symposium which will appear in the November issue of the Journal.

Edited by Wallace Herrell, M.D., Lexington, the symposium will include six papers by Kentucky physicians covering various aspects of lung cancer.

Physicians participating in the symposium issue are: Oscar O. Miller, M.D., Louisville; Kenneth D. McGinnis, M.D., Lexington; William M. Christophersen, M.D., Louisville; Marc J. Reardon, M.D., John R. Woodyard, M.D., and Edgar Wipperman, M.D., Covington; James B. Holloway, M.D., Lexington; and Jesshill Love, M.D., and Wesley Farnsley, M.D., Louisville.

A full listing of symposium subjects and participants appeared in the Organization Section of the September issue of the Journal.



Downtown Dallas, heart of a metropolitan area with over 1 million population, presents one of the nation's most dramatic skylines. It includes the two tallest buildings west of the Mississippi River. In the foreground is the new Memorial Auditorium, site of the 13th clinical meeting of the American Medical Association.



Featured speaker at a meeting of Lexington civic clubs and the Fayette County Medical Society, Louis M. Orr., M.D., Orlando, Fla., president of the AMA, (center) got together with leaders of the various groups. From left to right are —Robert W. Robertson, M.D., Paducah, KSMA president; W. O. Preston, M.D., Lexington, president of the Fayette County Medical Society; Jack Ward, Lexington, of the Kentucky Life Underwriters Association; Crawford Meyer, Louisville, president of the Kentucky Pharmaceutical Association; Wade Mountz, Louisville, president of the Kentucky Hospital Association; and Lyman Wagers, D.M.D., president of the Kentucky Dental Association.

Lexington Clinic Conference Set for October 21-22

The Fourth Annual Fall Clinical Conference of the Lexington Clinic is scheduled for October 21-22 at the new clinic building on South Broadway in Lexington.

Symposiums and scientific presentations will highlight the two-day meeting which will start on Wednesday at 10 a.m. KSMA members are cordially invited to attend the meeting.

A complete listing of topics and participants in the Conference was listed on page 1083 of the September, 1959, issue of the Journal.

Kentucky M.D.'s to Participate In Conference on Aging

Three Kentucky physicians are scheduled to be on the program of a regional conference sponsored by the Committee on Problems of the Aging of the AMA's Council on Medical Services, Oct. 28-29 at the Hotel Cleveland in Cleveland, Ohio. The region is comprised of Kentucky, Indiana, Ohio, Michigan and Pennsylvania, and a wide range of lay organizations from these five states will be invited to send representative to the two-day meeting.

Irvin Abell, Jr., M. D., Louisville, new president of KSMA, will preside at the luncheon meeting on Wednesday, October 28, at which Miss Chloe Gifford, Lexington, president of the National Federation of Women's Clubs, will be the principal speaker.

W. Vinson Pierce, M.D. Covington, KSMA delegate to the AMA and a member of the AMA's Committee on Health Insurance, will speak at 9 a.m. Thursday on health insurance as it relates to the aged.

Also on the morning program will be A. Clayton McCarty, M.D., Louisville, new chairman of KSMA's Committee on Problems of the Aged, who will tell about what is being done in Kentucky in the field of the aging.

Dr. Orr, AMA President, Speaks to Lexington Civic Clubs

"Too many Americans are growing old too soon," said Louis M. Orr, M.D., Orlando, Fla., president of the AMA, in a speech before Lexington civic clubs on September 1. He blamed this condition on: a fear of aging, forced retirement, and inactivity and boredom in later years.

Doctor Orr discussed the process of aging at the Guignol Theater at the University of Kentucky. His talk was sponsored by the Fayette County Medical Society and the civic clubs of Lexington.

"The human mind plays an equally important role with the body in the process of aging," he said, and, he added, "a man's mind never loses its youthfulness."

"Some strange workings of the modern mind seem to have settled on the age of 65 as the dividing line between middle age and old age. Such a designation may have had some validity 50 or 100 years ago, but today such an arbitrary designation is absurd," he said.

Doctor Orr said, "Among previous generations, an old man was rather unusual, but today with 16 million Americans over the age of 65, the needs of the elderly have become of major importance to a large part of our population."

He lauded the cooperation of the KSMA with the Council on Allied Medical Services in preparing a bill on indigent care for introduction in the next session of the State Legislature. He also noted that the Association had been working closely with "Blue Plans" and the health-insurance firms to develop low premium insurance especially for the aged.

Watch For

Annual Meeting News in Nov.

Be sure to read the November issue of the Journal for the report on the 1959 KSMA Annual Meeting which adjourned as the Journal went to press.

London TB Seminar Scheduled for October 29

Five Louisville physicians will be featured on the program of the postgraduate seminar at the District Five State TB Hospital in London on October 29, according to Thomas H. Biggs, M.D., medical director and superintendent.

The program is being presented by the hospital with the cooperation of the KSMA and the KAGP. Physicians participating in the program are: L. T. Minish, M.D., Ellis Fuller, M.D., John Harter, M.D., Hoyt Gardner, M.D., and Ralph Denham, M.D.

Seventeen counties are included in the District.

The complete seminar program appeared on page 1083 of the September 1959, issue of the Journal.

Commission Anounces Schedule of October Clinics

The October clinic schedule of the Kentucky Crippled Children Commission was announced recently by Marjorie K. Smith, M.D., Louisville, medical director.

The Commission offers services to children whose parents are indigent or unable to pay total amount of care. Since children are referred according to set districts it is important that appointments be made either through the Kentucky Crippled Children Commission, P. O. Box 65, Shelby Station, Louisville 17 or Out-Patient Department, Kentucky Crippled Children Commission, c/o Cardinal Hill Convalescent Home, Versailles Pike, Lexington.

Following is the schedule for the remainder of the month:

Louisville District—Kosair Crippled Children Hospital

Oct. 13—Orthopedic
Oct. 15—Orthopedic
Oct. 16—Scoliosis
Oct. 20—Orthopedic
Oct. 21—Cerebral Palsy
Oct. 22—Orthopedic
Oct. 23—Orthopedic

Lexington District—Cardinal Hill Convalescent Home

Oct. 15—Plastic Surgery
Oct. 16—Orthopedic
Oct. 21—Cerebral Palsy
Oct. 23—Orthopedic

Covington District—Treatment Center

Oct. 14—Orthopedic
Oct. 28—Cerebral Palsy

Paducah District—West Kentucky Center for Handicapped Children

Oct. 15—Cerebral Palsy

Ashland District—Bellefonte Hospital

Oct. 26—Cerebral Palsy

Field Clinics

Prestonsburg, October 27, Floyd County Health Dept. (includes Floyd, Johnson, and Martin Counties)
Harlan—Oct. 30—Harlan County Health Dept. (includes Harlan county).

Selective Service Advice Issued on Residency Training

The importance of considering liability for military service in accepting physicians for residency training in hospitals and medical schools is stressed in a directive issued by Lewis B. Hershey, director, National Headquarters, Selective Service System, Washington, D. C.

The directive, released by Lt. Col. Sam E. Hicks, director of State Headquarters for Selective Service, Frankfort, requests:

1. That local boards of the Selective Service System be informed that a physician should not be placed in Class II-A to complete residency training unless in the opinion of the local board his services are absolutely essential to the operation of the hospital or he is a participant in a residency training program of the Armed Forces or Public Health Service.

2. That all other physicians who are not veterans may be ordered to report for induction, if a call for physicians is placed upon the Selective Service System during their residency training.

Seminar on Alcoholism Planned In Louisville, Nov. 5

A Seminar on Alcoholism featuring outstanding authorities in this field will be presented at the Brown Hotel in Louisville on Thursday, November 5.

Kentucky physicians are cordially invited to attend the seminar which is being planned by the Kentucky Commission on Alcoholism in cooperation with the University of Louisville School of Medicine, Kentucky Academy of General Practice, Louisville Academy of General Practice, and the Kentucky Psychiatric Association. The program has been approved for 7 hours of Category 1 credit by the American Academy of General Practice.

Moderator for the day-long session will be Louis M. Foltz, M.D., Louisville, chairman of the Kentucky Commission on Alcoholism.

Following is the complete program:

9:00 a.m. **"Alcoholism"**
Marvin A. Block, M.D., chairman, Committee on Alcoholism, AMA

9:30 a.m. **Question and Answer, Discussion Period**

10:00 a.m. **"Physiology and Pharmacology of Alcohol: Some Critical Questions"**
Thomas G. Scharff, Ph.D., Department of Pharmacology, School of Medicine, University of Louisville

10:30 a.m. **Question and Answer, Discussion Period**

11:00 a.m. **Coffee Break**

11:15 a.m. **"Alcoholism, A Public Health Program"**
John A. Lewis, M.D., Alcoholism Consultant, U.S. Public Health Service

12:00 a.m. **Lunch**

1:15 p.m. **"Alcoholism, The Nutritional Approach"**
Roger J. Williams, Ph.D., D. Sc., Director, Clayton Institute, Bio-Chemical Research, Austin, Tex.

2:00 p.m. **Question and Answer, Discussion Period**

2:30 p.m. **"Motivation of the Alcoholic"**
Edward J. Delehanty, M.D., chairman, Colorado Commission on Alcoholism

3:15 p.m. **Question and Answer, Discussion Period**

3:45 p.m. **"Medical Treatment of Alcoholism"**
Marvin A. Block, M.D.

4:30 p.m. **Question and Answer, Discussion Period**

5:00 p.m. **Film—USPH Service, "Research in Alcoholic Intoxication"**

5:20 p.m. **Adjournment**

Conference registration fee will be $5 and will include the cost of the luncheon and coffee break.



Meeting with Louis M. Orr, M.D., AMA president (center) during a gathering of civic and medical leaders at which he spoke were: W. O. Preston, M.D., president of the Fayette County Medical Society; Fred B. Wachs, editor and publisher of the Lexington Herald-Leader; J. Farra VanMeter, M.D., Lexington, program chairman; N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Service.

New KSMA President Appoints Committees for '59-60

Members of KSMA's President Appointed Committees were announced by Irvin W. Abell, Jr., M.D., Louisville, following his inauguration as 1959-60 KSMA President on September 23.

Following are the committees selected by Doctor Abell to serve in the coming year:

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Malcolm D. Thompson, Louisville
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Alfred O. Miller, Louisville
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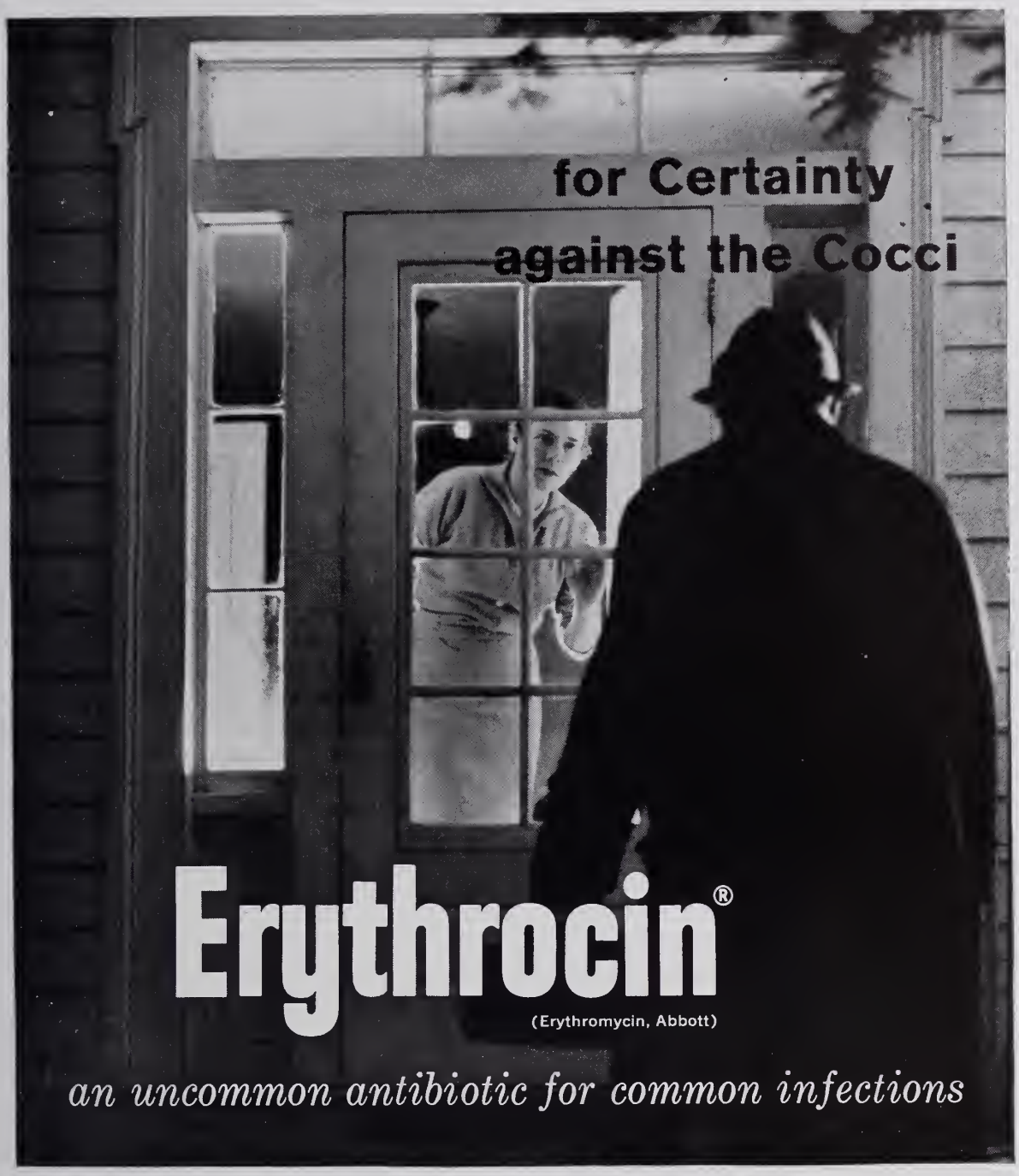
Society Elects Dr. McCarty

A. Clayton McCarty, M.D., Louisville, new chairman of KSMA's Committee on Problems of the Aged, last month was elected vice president of the American Geriatrics Society and also named to the four-man Advisory Council of the society which has several thousand members. The group's next meeting will be held in Miami.

Dr. Knisely Gets Cancer Grant

William H. Knisely, M.D., a faculty member of the new University of Kentucky College of Medicine, will conduct an 18-month study of growth rates of cancer in different parts of the body under a recently announced $27,809 research grant announced by the Kentucky Division of the American Cancer Society.

Announcement of the grant, one of 211 totaling $4,763,000 made by the American Cancer Society was made by Henry B. Asman, M.D., Louisville, president of the Kentucky Division, ACS. Doctor Knisely will also study effects of various chemicals on cancer in experimental animals.



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Student AMA

Joy and apprehension were exhibited as ninety-nine incoming freshmen registered for their first year at the University of Louisville Medical School on September 11, 1959. It was an experience we can recall with vividness; an experience we will never know again.

The University of Louisville Chapter, SAMA received much cooperation from the Dean's office in planning a welcoming weekend for these freshmen. It was our intention that such a weekend would foster a better relationship between faculty and student, as well as giving the latter a feeling of "belongingness."

A luncheon was served in the Louisville General Hospital cafeteria following the Dean's orientation hour. Members of the freshmen faculty and the chairmen of all departments were invited and asked to intermingle with the freshmen. This was quite effective, and we were pleased that our freshman orientation program had begun so well.

Sunday, one day PTA (prior to Doctor Arch Cole's gross anatomy), a picnic was held at Doctor Landis's farm near Eastwood, Ky. Freshmen and their spouses were invited as were faculty members. The "turnout" was excellent, the weather was delightful, and all-in-all a fine time was had by everyone present.

After "rehashing" the week-end with several medical school freshmen, we are convinced that our objectives were accomplished; that this class had a good feeling toward U of L Medical School upon assuming classes.

That the new prospective doctors felt pleased with SAMA is attested by the number of freshmen joining our organization. Over eight-five per cent became members within one week after school started.

Much thanks is extended to Dean Kinsman, Miss Mary Gans, and Doctor Landis for their time and interest in this worthwhile program. To the many others who actively took part, we extend our gratitude.

Robert K. McKechnie
President, U of L Chapter
Student American Medical Association

Museum Room Honors Dr. Elkin

The late Dan C. Elkin, M.D., of Lancaster and Atlanta, Ga., former president of the American College of Surgeons, will have a memorial room named for him at the Kentucky Life Museum near Lexington. The museum, operated by the University of Kentucky, will include a room set as Doctor Elkin's study. Doctor Elkin was once vice president of the Kentucky Medical Foundation. He was professor of suregry at Emory University for 23 years and was recognized as a pioneer in methods and techniques of vascular surgery.

U of L to Conduct Research

Three University of Louisville medical school professors will conduct research under a $18,031 grant from the National Foundation, which conducts the annual March of Dimes Drive in January. Doctors Alex J. Steigman, Murray M. Lipton, and Waldon B. Wacker, will seek answers on how immunity works in the body, including the phenomenon of "immunological tolerance."

Research will be done at the Kentucky Child Health Foundation Hospital laboratory at the medical school. Research will be directed by Doctor Lipton, associate professor of child-health research in the pediatrics department; aided by Doctor Wacker, a new faculty member who is assistant professor of child-health research. Doctor Steigman is chairman of the department of pediatrics. The department has been conducting research concerned with infection and protection in newborn and young infants for several years.

Ruskjer Elected Vice Pres.

S. A. Ruskjer, administrator of the Waverly Hills Tuberculosis Sanatorium, has been elected second vice president of the American College of Hospital Administrators. The college, the professional accrediting group for hospital administrators, held its annual meeting in New York in September. At that time, Wade Mountz, administrator of Norton Memorial Infirmary in Louisville, became a fellow of the College.

Dr. Bouton on State Board

According to press dispatches, the late Carl J. Johnson, D. O. Louisville, has been replaced on the State Board of Health by E. H. Bouton, D. O., Frankfort. Doctor Bouton will fill the unexpired term of Doctor Johnson which expires on January 17, 1962. Appointment was made by Governor A. B. Chandler.

The Mid-West Forum on Allergy will hold its third annual Meeting on October 31 and November 1 at the Sheraton-Blackstone Hotel, Chicago. This meeting of the Forum is sponsored by the Chicago Society of Allergy. For further information, please write, Leon Unger, M.D., 185 North Wabash Avenue, Chicago 2, Ill.

Physicians from all parts of the U. S. and Canada who practice medicine as members of a group or clinic gathered in Chicago at the Sheraton-Blackstone Hotel on September 24-26 for the 10th Annual meeting of the American Association of Medical Clinics.

Twentieth annual meeting of the American Fracture Association is scheduled for New Orleans, La., on November 1-4. The four-day meeting will be conducted in the Roosevelt Hotel. It will include a postgraduate instructional course in fractures. An optional trip to the Leprosarium, Tulane University, on November 5th will be an adjunct to the meetings. Scientific sessions will be held all four days of the meeting. Reservations should be secured directly from the Hotel Roosevelt.







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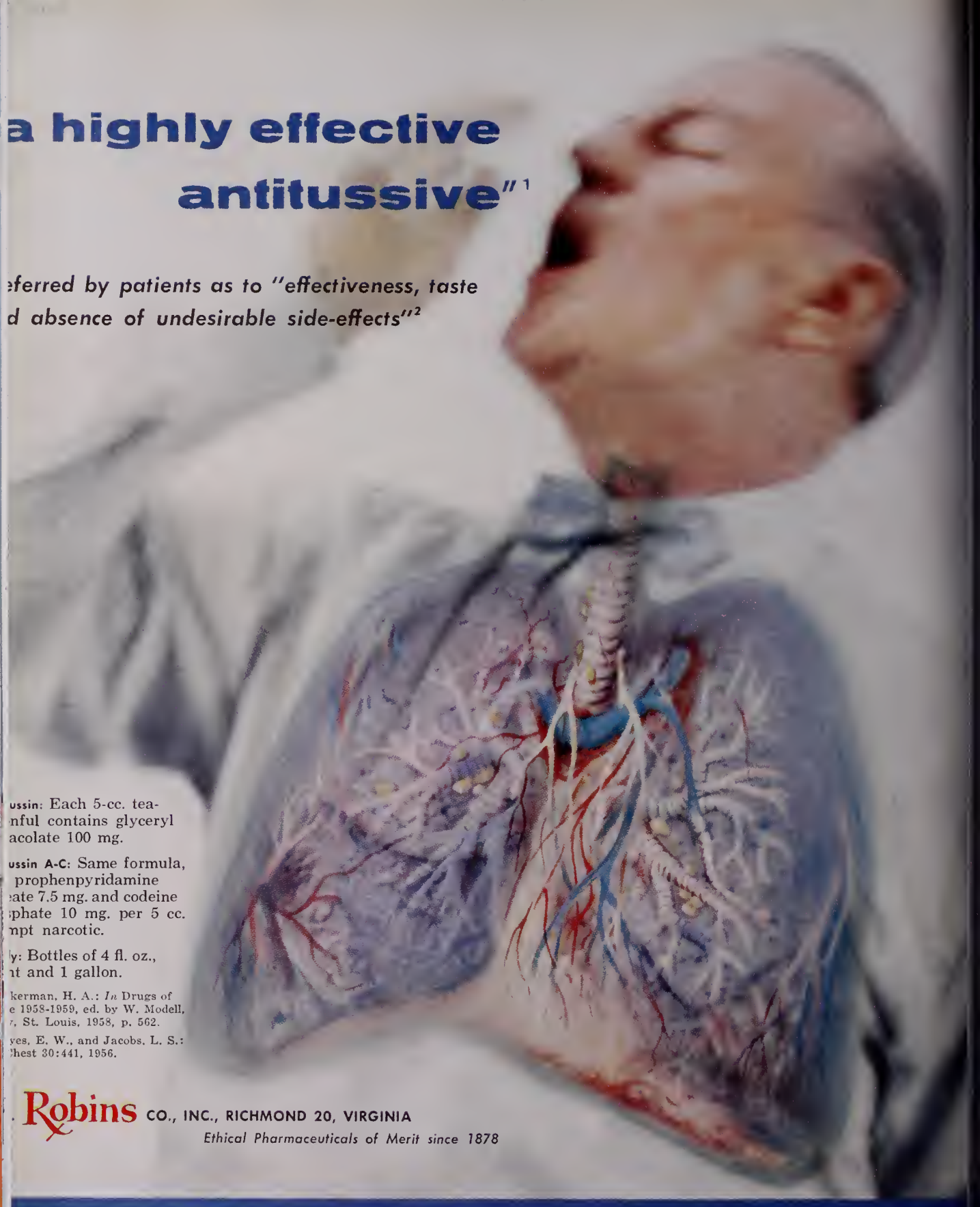
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kerman, H. A.: *In* Drugs of e 1958-1959, ed. by W. Modell, , St. Louis, 1958, p. 562.

yes, E. W., and Jacobs, L. S.: hest 30:441, 1956.

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Dallas, population 1,050,000, is rapidly becoming one of the great convention centers of the nation. It combines old fashioned Texas hospitality with some of the most modern convention facilities to be found anywhere. It has excellent skyscraper hotels, and numerous night clubs and restaurants presenting top-flight entertainment.

Cultural facilities include the famous Margo Jones theatre, the Dallas Civic Opera and the Dallas Symphony Orchestra.

PROGRAM HIGHLIGHTS

The Role of Medicine in the Space Age—Hubertus Strughold, Professor and Advisor for Research, School of Aviation Medicine, Randolph AFB

Indications for Hysterectomy—Willis H. Jondahl, Harlingen, Texas—Lecture

Rheumatoid Arthritis—W. Paul Holbrook, Tuscon, Ariz. Panel Moderator

Colloidal Isotopes and Leukemia—Joseph M. Hill, Dallas—Lecture

Treatment of Diabetes—Randall G. Sprague, Rochester, Minn.—Panel Moderator

Infectious Diseases in Children—Harris D. Riley, Jr., Oklahoma City—Panel Moderator

Tranquilizers in Medical Practice—Stewart Wolf, Oklahoma City—Lecture

Surgical Approaches to Parkinson's Disease—William W. McKinney, Fort Worth—Lecture

Congestive Heart Failure—James V. Warren, Galveston—Panel Moderator

Peptic Ulcer in Rheumatoid Arthritis—Lloyd G. Bartholomew, Rochester, Minn.—Lecture

Immunization and its Future—Blair E. Batson, Jackson, Miss.—Lecture

Children's Eyes—Tullos O. Coston, Oklahoma City—Lecture

Obstetrical Emergencies—Willis E. Brown, Little Rock, Ark.—Panel Moderator

Hernia Repair—Francis C. Usher, Houston—Lecture

Premarital and Marital Counseling—Oren R. Depp, New Orleans—Panel Moderator

Anticoagulants and Choice of Drugs—James W. Culbertson, Memphis, Tenn.—Lecture

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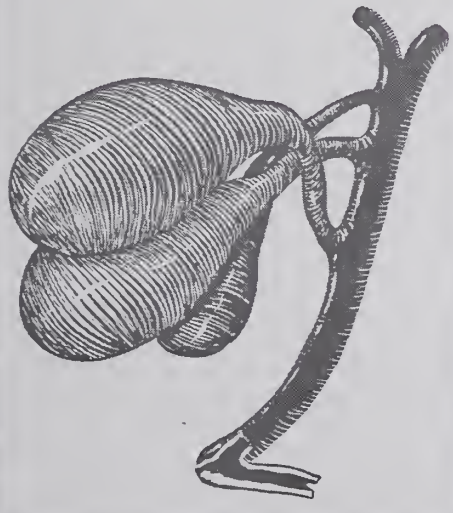
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Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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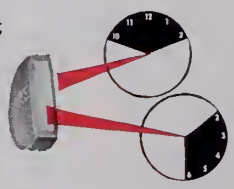
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Refereneces: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

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In Memoriam

CLARENCE MORGAN BROWN, M.D.
Adairville
1875-1959

Clarence Morgan Brown, M.D., retired Logan county physician, died August 15 at Midstate Baptist Hospital at the age of 84.

Doctor Brown was born in Logan County in 1875, and was a veteran of 40 years medical practice in that county. He graduated from the University of Tennessee and lived and practiced in Adairville for most of his life with the exception of 10 years when he was in Hazard.

C. W. JEFFERSON, M.D.
Louisville
1889-1959

Charles W. Jefferson, M.D., Louisville surgeon, died at St. Anthony Hospital in Louisville on September 2 at the age of 70.

Doctor Jefferson was a former president of the staffs of St. Anthony and Jewish Hospitals and a fellow in the International College of Surgeons. The oldest member of the "L" Club at the University of Louisville, he graduated from the School of Medicine in 1910. A native of Louisville, he had served in the medical corps of the American and British armies.

FRANCIS B. ZIMMERMAN, M.D.
Louisville
1908-1959

Francis B. Zimmerman, M.D., who limited his practice to eye, ear, nose, and throat, died at his home in Louisville on September 13 after a long illness.

A Louisville native, Doctor Zimmerman began a general medical practice in Louisville in 1935, following his graduation from the University of Louisville in 1933 and postgraduate study at Washington and Lee University. After seven years of general practice, he studied two years at Gill Memorial Hospital, Roanoke, Va., and interned at General Hospital in Louisville. He was a past president of the Kentucky Eye, Ear, Nose, and Throat Society.

Deborah Hospital will hold its second international symposium on Changing Concepts in Medicine (Congenital Heart Disease) at the Bellevue-Stratford Hotel in Philadelphia, Pa., on April 28, 29, 30, 1960. Inquiries should be addressed to: Charles P. Bailey, M.D., The Deborah Hospital, Browns Mills, N. J.

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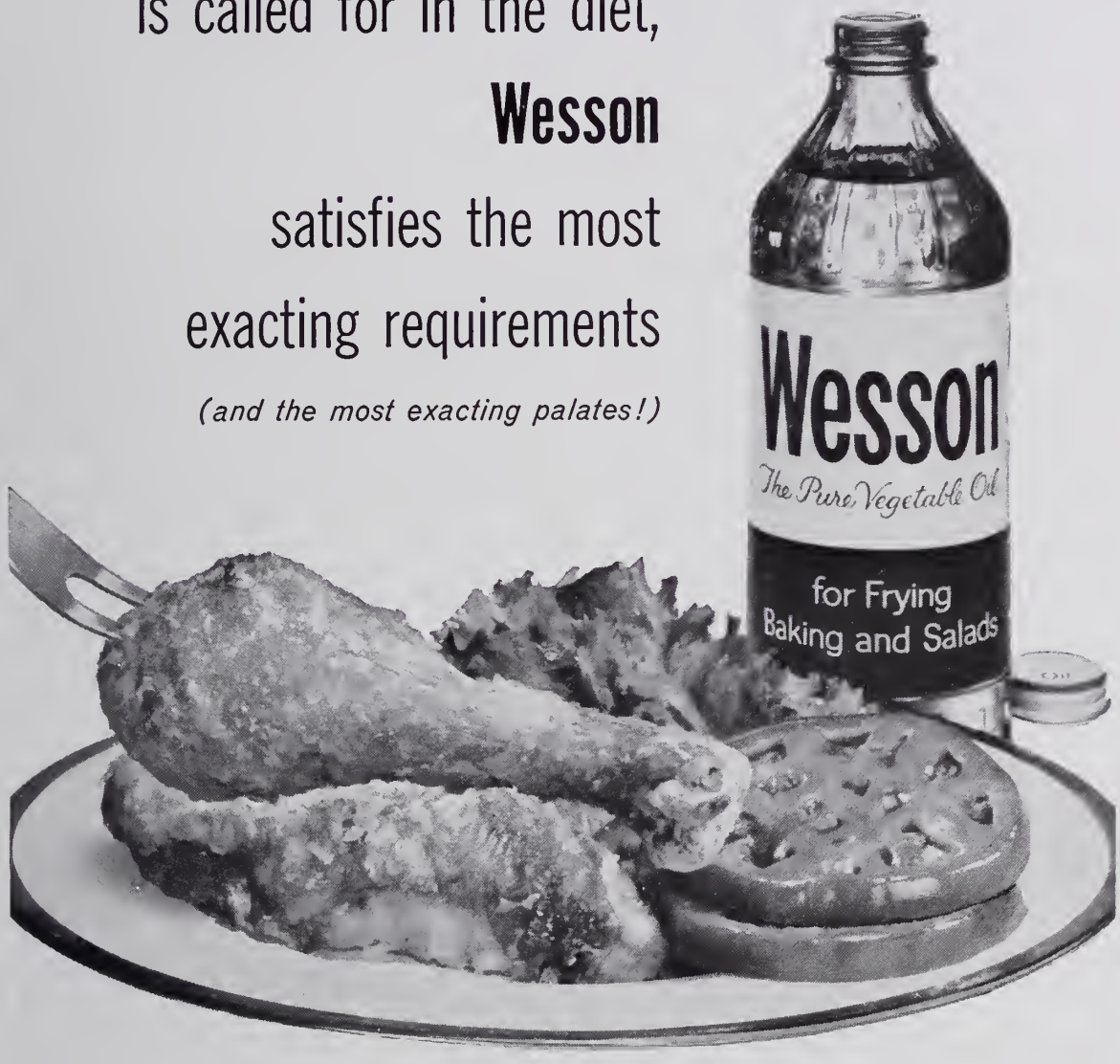
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News Items

William W. Hall, M.D., is now in general practice in Owensboro. Doctor Hall graduated from the University of Louisville School of Medicine in 1954. He interned at Charity Hospital in New Orleans and has just completed one year's training in general practice at the Medical Center, Columbus, Ga. Doctor Hall practiced in Middlesboro at the Middlesboro Memorial Hospital in 1955-56.

Joseph R. Bolton, M.D., a native of Hazard, has started practicing general surgery, in Paris. Doctor Bolton graduated from the University of Louisville School of Medicine in 1954, interned at Louisville General Hospital, and took his residency in surgery at St. Joseph's Infirmary, Louisville and Louisville VA Hospital.

Norman Keith Kirby, M.D., has located in Burkesville, where he will be in general practice. A graduate of the University of Louisville School of Medicine in 1956, Doctor Kirby interned at Louisville General Hospital. He has just completed a two year tour of duty with the U. S. Medical Corps, stationed at Fort Knox. Doctor Kirby was born in Kettle, Ky.

Ellis Jones, M.D., a native of Fordsville, is now in general practice in Owensboro. Doctor Jones previously practiced in Oklahoma. He graduated from the old Kentucky School of Medicine (now U of L) in 1907.

Answer to CPC

(Continued from page 1231)

therein would, through a series of related actions, bring about the depolymerization of desoxyribonucleoprotein.[6]

Summary and Conclusion

A case of an apparently new disease, pulmonary alveolar proteinosis, was treated by the inhalation of a solution of Varidase® using intermittent positive pressure breathing. The simultaneous gradual disappearance of symptoms and the clearing of the pulmonary infiltrates suggests that this treatment may be of some real value.

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7. Clinicopathologic Conference: Jour. Ky. State Med. Assn., 57: 1076-1077, Sept. 1959.

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Adults and older children	1	2	three times daily
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Pertinent Paragraphs

About 438 million acute illnesses involving either restricted activity or medical attention or both occurred among the American people during the year ending June 30, 1958. The number of such illnesses averaged 2.6 for every person in the population. The figures are from the newest report of the U. S. National Health Survey, which shows that the highest incidence was in the youngest age groups and decreased progressively in each older age group. The report, "Acute Conditions, Incidence and Associated Disability, United States, July 1957-June 1958" is Public Health Service Publication No. 584-B6.

The eighth congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, September 28 through October 5 in 1960. All members of the profession are invited to attend and are urged to make reservations early if they wish to be assured of adequate facilities. For further information write: F. J. Pinkerton, M.D., Director General of the Pan-Pacific Surgical Association, Suite 230, Alexander Young Building, Honolulu 13, Hawaii.

A grant of approximate'y $200,000 from the National Heart Institute of the U. S. Public Health Service to New York University-Bellevue Medical Center for a five-year study of cardiovascular rehabilitation, has been announced by George E. Armstrong, M.D., director of the Center. The project, which is concerned with preventive measures that will make possible the early recognition and delaying of coronary heart disease, is under the direction of Howard A. Rusk, M.D., professor and chairman of the department of physical medicine and rehabilitation and Menard M. Gertler, associate professor and director of research.

Declaring that in modern medicine it is basic knowledge that needs to be increased "as rapidly as possible" the nation's drug manufacturers urged the government to give top priority to basic medical research programs. In a 1000-word statement of principle, the Pharmaceutical Manufacturers Association warned that the U. S. faces a 25 per cent deficit in the number of medical scientists needed by 1970.

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Case #43:

The patient was a 42-year-old married colored gravida 15, para 14 who was due by menses 5/12/58, her L M P being 9/5/57.

She consulted her private physician in her fourth month of pregnancy, had a complete medical examination and had seven prenatal visits. Her past history was negative.

	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May			
B/P				120/80	110/70			100/70	120/70	100/70	140/70	118/70
Wgt.				138	143½			150	149½	153½	149¾	155½
Urine				neg.	neg.			neg.	neg.	neg.	neg.	neg.

Rh+
Hgb. 12.5 grams
VDRL neg.

She did have pitting edema of her feet and ankles on her last three visits beginning 5/9/58. She was treated with "Diuril®, rest and diet."

Labor apparently began spontaneously around 7:00 p. m., 5/27/58. The cervix was dilated 4 cm and she was described as making normal progress until apparently 11:30 p. m., when she had profuse vaginal bleeding and the fetal heart was described as weak. (No mention was made of cervical dilation at this time.) It was stated that she had received no analgesic.

Consultation was obtained; two consultants suggested transfusion and section. A classical section was done immediately under cyclopropane and oxygen. The patient was described as being in good condition and the baby was a normal 6 lb., 8½ oz. girl. At approximately 11:45 p. m. the patient's blood pressure fell to 0. She never regained consciousness. No mention was made as to whether the patient was still having excessive bleeding. She expired at 3:45 a. m. in spite of transfusions of 2000 cc blood, 1500 cc plasma, 2000 cc 10% G/W, pitocin, ergotrate, adrenalin, levophed. Source of the hemorrhage was said to be uterine.

No autopsy was obtained.

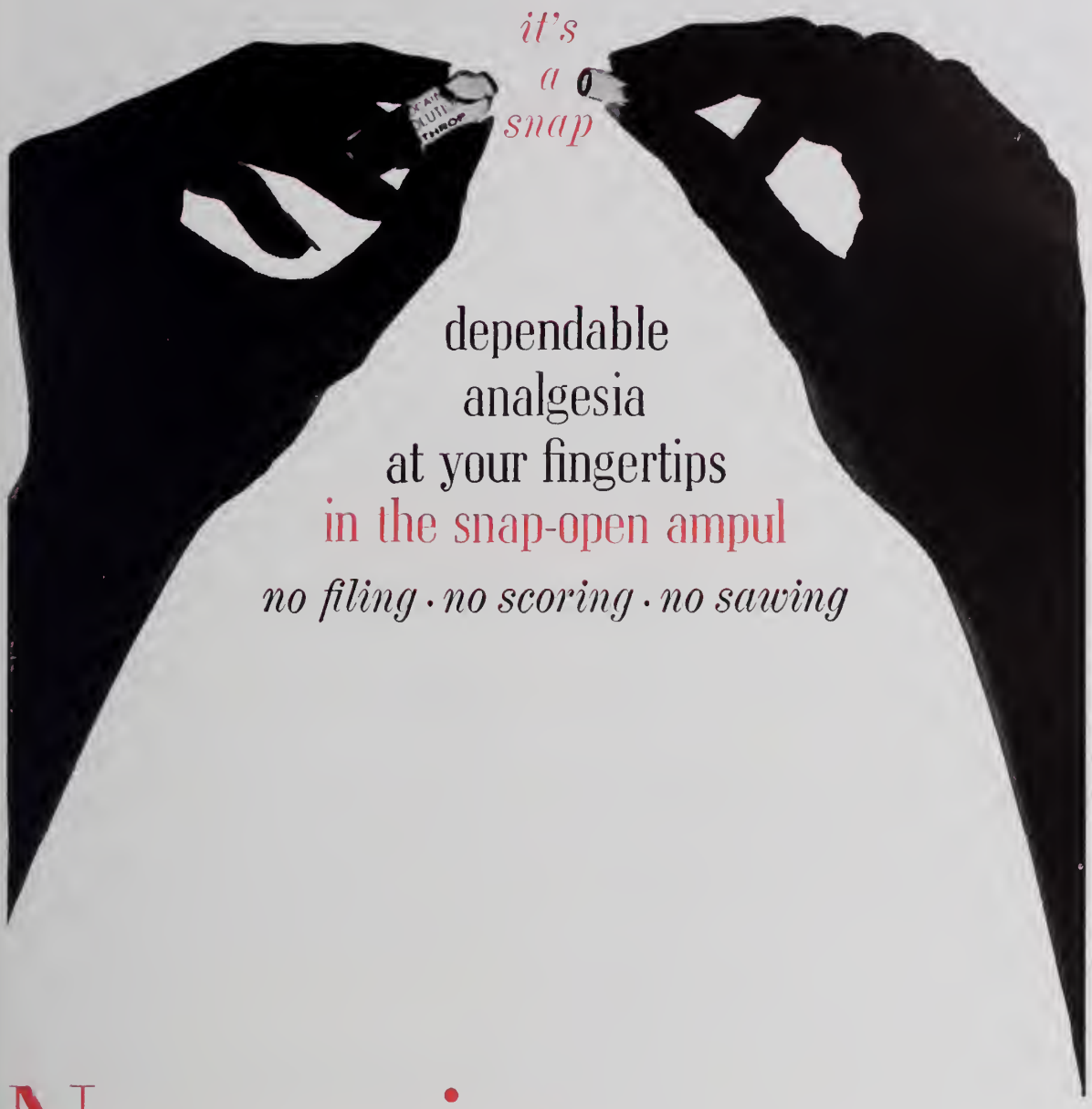
Cause of death on the death certificate was "uterine hemorrhage, postpartum, due to abruptio placentae totalis."

Comment

The committee felt this was a direct obstetric death with the cause of the uterine hemorrhage undetermined from the facts supplied on the abstract. This case was presented in part to reacquaint the physician with the need for giving as much information as is available.

There were several things that could have accounted for the hemorrhage in this case, though from the information supplied it was impossible to say which was actually responsible. With a sudden severe abruptio placentae the bleeding could have been from hypofibrinogenemia. No mention was made as to whether the blood clotted. It wasn't clear if the 'shock' occurred on the operating table during the closure, as the time given would have implied. In any event, some four hours elapsed before she died, and certainly reopening the abdomen and tying off the uterine vessels or hypogastric vessels or a hysterotomy might have controlled the bleeding or explained the source.

This patient, a grand multipara, had more prenatal visits than the majority of the cases reviewed. Even though she realized the importance of early, frequent prenatal visits, the outcome was fatal. Current studies still support the greater hazards that accompany grand multiparity both to the mother and the infant. The physician who feels the only thing necessary is to get there in time to catch the baby is fooling not only himself but also unfortunately his patient.



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LESIONS OF THE LOWER BOWEL: by Raymond J. Jackman, M. D., M. S.; published by Charles C. Thomas, Springfield, Ill.; 1958; 347 pages with 131 illustrations; price, $15.50.

This excellent book should appeal not only to the proctologist and general surgeon but also to the general practitioner and gastroenterologist. The author has clearly and concisely described and illustrated the diagnostic studies pertaining to the finding and recognition of the lesions most frequently encountered in the lower bowel.

Fifty-six black-and-white illustrations and a marvelous color atlas of 75 plates aid this study and add to the usefulness of the book as a ready reference. The 28 chapters are individually indexed with a subject matter heading for easy reference which makes it an ideal book in a working library. One may quickly locate numerous color plates of polyps, malignant lesions, mucosal ulcerations, diverticulae and different types of rectal prolapse which make the book a guide for the clinician and the experienced as well as the inexperienced proctoscopist.

The variety of lesions of an inflammatory and neoplastic nature, along with the variations from the normal mucosa of the bowel are most beautifully illustrated by endoscopic photographs.

The chapter on technique includes a simple step by step proved method of proctoscopy as well as the more complicated techniques of trans-rectal needle biopsy.

This book is not only an excellent and easy reference, but a masterpiece of photography. It includes the lesions most frequently seen, as well as the more rare conditions. This book should be in the library of any physician who is interested in the lower gastrointestinal tract.

Wilford L. Cooper, M.D.

GYNECOLOGIC RADIOGRAPHY: by Jean Dalsace, M.D., and J. Garcia-Calderon, M.D., published by Paul B. Hoeber, Inc., 1959; 206 pages with 360 illustrations: price, $8.

This is an excellent atlas of gynecologic radiology treating many important problems of gynecologic pathology by means of contrast roentgenograms.

It is proper and fitting that this atlas should be the work of French physicians, since hysterosalpingography is the ingenious discovery of two French authors, J. A. Sicard and J. Forestier, who, as long ago as 1922, advocated Lipiodol as a harmless contrast medium.

Introductory chapters, devoted to method, complications, embryology, anatomy, and physiology, furnish a background for the subsequent roentgen observations. The concise text contains more than 300 illustrations and demonstrates the findings in a wide variety of clinical problems, including uterine flexion and version, fibroids and polyps, cancer of the cervix and corpus uteri, tubal obstruction, ovarian cysts, incomplete abortion, peritubal adhesions, etc.

The chapter on cervical and uterine cancer is more abundantly illustrated than any other of this atlas. The authors admitted the limitations of hysterography in such problems, but emphasized the importance of demonstrating a clearly limited suspicious localized lesion as indicated by the hysterogram before a curettage is performed. Many gynecologists are still skeptical about the value of hysterography for cancer detection; some even consider this method dangerous and instrumental in disseminating cancer cells.

The final chapter on radiography of breast, contributed by Charles M. Gros, M.D., and Robert Sigrist, M.D., reveals the potential value of a new tool for diagnosis of infection, dysplasia, benign and malignant tumors. They demonstrate, in a literal sense, the fact, that the breast is an auxiliary of the female genital organs.

The book is an unusually concise and easily understood presentation of a complex subject. The completeness of the presentation is indeed remarkable. The quality of the roentgenograms is excellent. The work can be recommended without reservation to gynecologist, obstetrician and radiologist.

J. T. Ling, M.D.

STRABISMUS OPHTHALMIC SYMPOSIUM II, edited by James H. Allen, M.D.; published by C. V. Mosby Company, St. Louis, Mo., 1958; 552 pages, 251 illustrations; price, $16.

Like its predecessor this volume brings to the ophthalmologist an authoritative and comprehensive review of the major areas of ocular motor anomalies.

The chapters are not mere summaries, but critical analyses of a vast amount of material. The observations and conclusions are carefully made by men who are actually engaged in investigative work in this field of ophthalmology. The first chapter deals with embryology, and gross and surgical anatomy of the extrinsic muscles. There is special emphasis on the facial anomalies, and the surgical anatomy of the oblique muscles is described in detail, all with many excellent illustrations.

The discussion of the etiology of commitant strabismus by Dr. Burian is most interesting. It illustrates the wide difference of opinions, and is evidence of the

In the Books

(Continued from page 1260)

uncertainty of our positive knowledge on this subject. At the end of the chapter Dr. Burian attempts to rationalize and coordinate this material and present briefly a possible solution to this problem.

The chapters that deal with the nature of normal binocular vision, fusion and the relationship of the sensory and motor components of binocular vision are capably presented by Dr. Swann. Emphasis is stressed on the dominant role which the sensory component plays. The motor responses are dependent on a normal functioning sensory mechanism.

The mental process of projection is explained and also the phenomenon of Panum's fusion area is illustrated.

Dr. Adler's contribution to the symposium deals with the neuroanatomy of the supra-nuclear pathways and the voluntary and involuntary mechanisms. Dr. Adler presented for the first time the result of his work with the electromyography which revealed that divergence is a positive act and not a relaxing of convergence alone. This has been substantiated by Dr. Brennen who also presented his findings on the electromyographic studies on humans. This data will cause a great many ophthalmologists to revaluate their thinking on divergence anomalies.

The portion of Dr. Guibor's presentation that appealed to me was his tables that listed the differential diagnostic points in (1) supra-nuclear and peripheral paralysis of the medial rectus muscles (2) differential diagnoses of paralytic strabismus from supra-nuclear deviations and (3) data used in differential diagnoses of hemespheric from pontine conjugate deviation.

The principles and technique of treatment of strabismus by Dr. Costenbader lists three objectives: (1) restoration and maintenance of good visual acuity (2) early restoration and maintenance of alignment of the visual axes by use of glasses, medication or surgery and (3) when sufficiently mature the patient should have active binocular stimulation. The treatment of strabismus is a long and continuing process but is well worth the time and effort expended.

The remainder of Dr. Costenbader's contribution is a detailed description of the various methods and techniques required in carrying out such a program.

Divergent deviations were classified into three categories: (1) exophoria (2) intermittent exotropia (3) frank or constant exotropia. A further subdivision: (a) deviations greater for near (b) deviations greater for distance (c) deviations, same for distance and near. The deviations that are greater for distance are always primary. Those greater for near may be primary or secondary to a deviation for distance.

The remainder of Dr. Knapp's presentation described in detail the characteristic finding in each of the above types and the method of treatment, whether it be surgical or nonsurgical, was discussed.

Dr. Harold Brown's contribution deals with congenital structural anomalies of the ocular muscles. A classification of these defects is presented and their surgical correction is described. He also elaborates on the retraction syndrome of the superior oblique which he first described in the symposium #1. The last chapter deals with surgery of the oblique muscles. The procedures are described in detail with appropriate illustrations.

I attended this symposim at New Orleans and I enjoyed the roundtable discussion more than any other portion. I am happy to see that some of these discussions were included in the volume. It was during these discussions that the differences of opinions of the few members of the panel were dramatized. One question that was answered by Dr. Burian, which I did not see in print, was, "What, if any, progress has been made in the knowledge of the etiology of strabismus since the first symposium?" Dr. Burian answered that he thought a great deal has been accomplished, especially in terminology, but that the confusion as to the etiology now is on a higher level.

Charles T. Moran, M.D.

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Milligram for Milligram, DECLOMYCIN exhibits 2 to 4 times the clinical potency (inhibitory action) of tetracycline against susceptible organisms. Thus, DECLOMYCIN has the advantage of providing significantly higher serum *activity* levels with significantly reduced drug intake.* [1,3,5]

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DECLOMYCIN maintains significant antibacterial activity for one to two days after discontinuance of dosage[1]—a major distinction from other antibiotics. Previous drugs have declined abruptly in activity following withdrawal.

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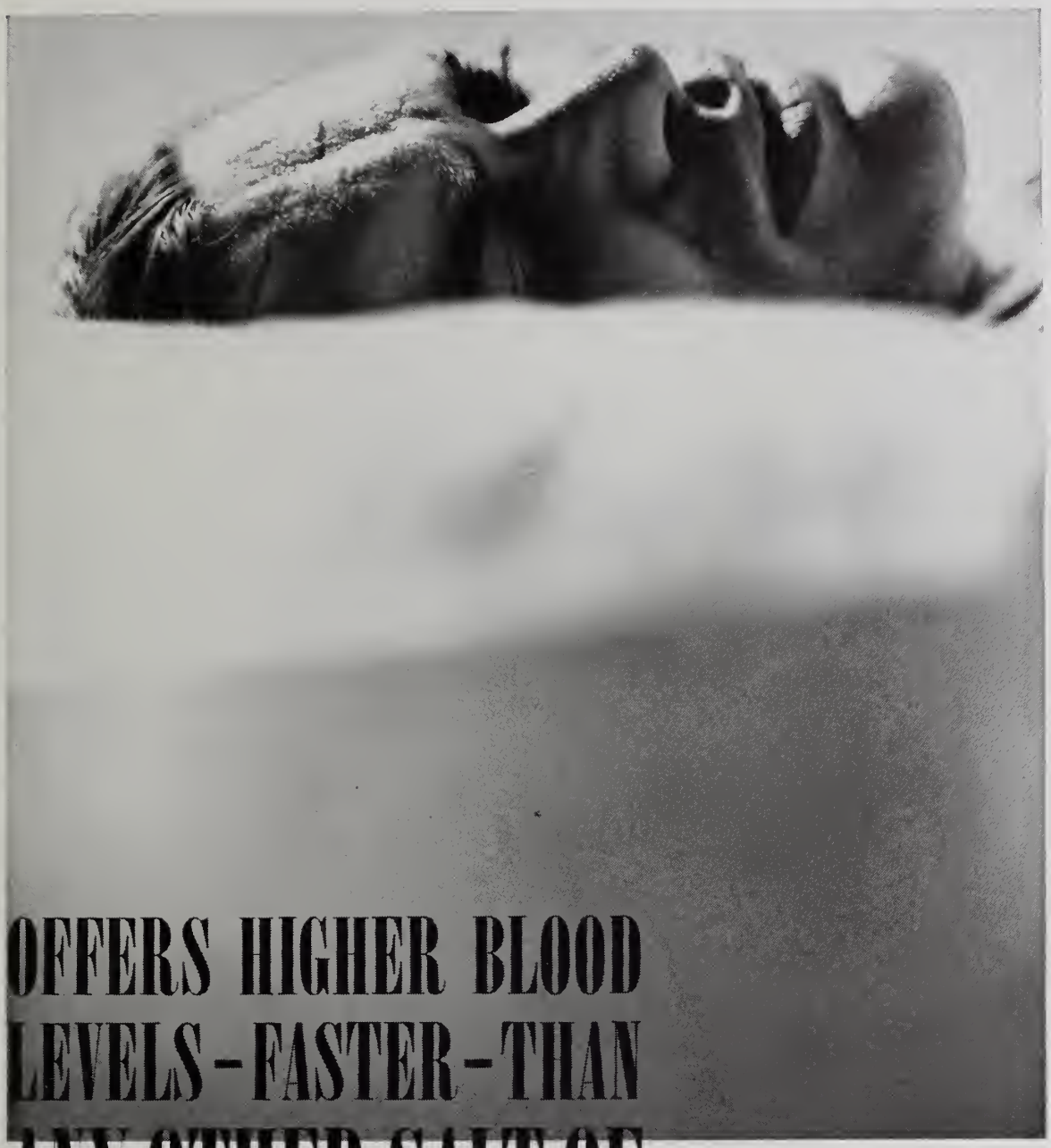
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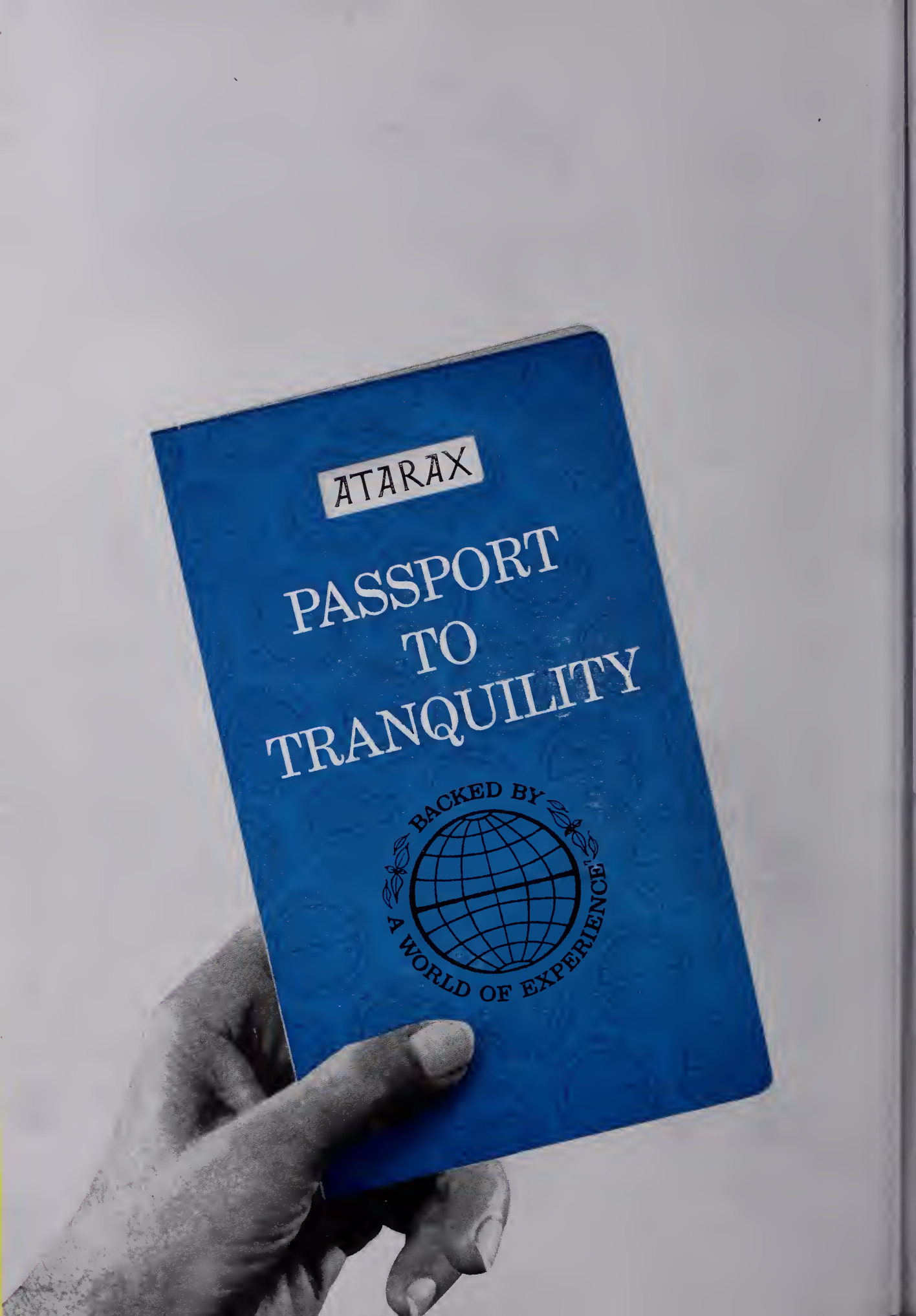
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Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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DELA

The results of administering Delalutin before the 12th week of gestation to 82 women with habitual abortion were reported recently by Reifenstein[1] in a compilation of data supplied by 45 investigators. Every patient had experienced at least three consecutive abortions immediately preceding the treated pregnancy. More than 68% of these women were delivered successfully and uneventfully following Delalutin therapy.

Boschann,[2] in a study of pregnancies with threatened abortion, found that:

37% of 73 pregnancies were carried to term without progestational therapy

64% of 42 pregnancies were salvaged by progesterone

83% of 73 pregnancies were salvaged by Delalutin

Eichner,[3] found that in Delalutin-treated women, fetal salvage of infants below term weight (1000 to 2000 gm.) was significantly improved. 108 (76%) of 142 babies of this birth weight survived without mothers receiving progestational therapy, while 16 (100%) of 16 babies of this birth weight survived with mothers receiving Delalutin therapy. A comparison study was made of a group of repeated aborters treated with Delalutin, and a group with a similar history treated with bed rest and sedation.[4] Pregnancy salvage with Delalutin was twice that of the control group. Delalutin was found to be "highly active", well-tolerated and long-acting.

According to Tyler and Olson,[5] "These qualities of prolonged action and relative freedom from local reactions make [Delalutin] a generally more desirable therapeutic agent for intramuscular use than progesterone . . . ."

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Randy Sinis
Denver, Colo.



Richard Miller
Denver, Colo.



Scott Knudsen
Norwich, Vt.

References: 1. Reifenstein, E. C. Jr.: *Annals N. Y. Acad. Sc.* 71:762 (July 30) 1958. 2. Boschann, H.W.: *ibid.*, p. 727. 3. Eichner, E.: *ibid.*, p. 787. 4. Hodgkinson, C. P.; Igna, E. J., and Bukeavich, A. P.: *Am. J. Obst. & Gynec.* 76:279, 1958. 5. Tyler, E. T., and Olson, H. J.: *J.A.M.A.* 169:1843, 1959.

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***DELALUTIN** offers these advantages over other progestational agents:*

- long-acting sustained therapy
- more effective in producing and maintaining a completely matured secretory endometrium
- no androgenic effect
- more concentrated solution requiring injection of less vehicle
- unusually well-tolerated, even in large doses
- fewer injections required
- low viscosity makes administration easier

DELALUTIN is also potent and safe therapy for: threatened abortion; postpartum afterpains; amenorrhea, primary and secondary; dysfunctional uterine bleeding not associated with genital malignancy; infertility with inadequate corpus luteum function; production of secretory endometrium and desquamation during estrogen therapy; premenstrual tension; dysmenorrhea; cyclomastopathy, mastodynia, adenosis and chronic cystic mastitis.

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ch of these healthy, normal babies was born by a mother with a documented previous history true habitual abortion, who was treated during her most recent pregnancy with DELALUTIN.



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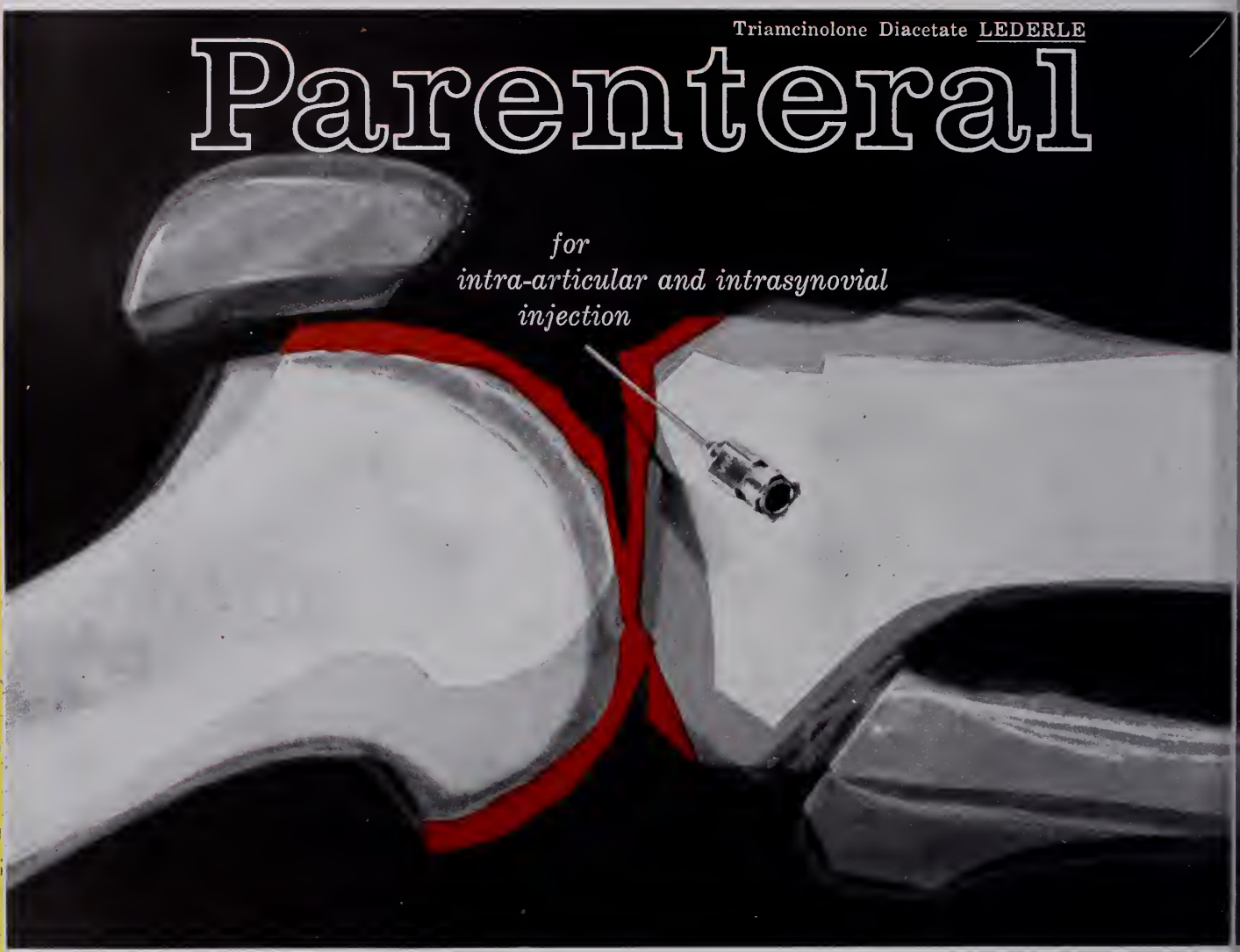
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- to secure quick relief in one or two joints
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Diagnosis: Rheumatoid arthritis.

Previous Therapy:
40 mg. triamcinalone per day.

Complicating States:
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Current Therapy: ARTHROPAN Liquid.

Results: The patient improved on ARTHROPAN and "...is now on Choline Salicylate [ARTHROPAN] alone and has returned to work."[1]



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1. Clark, G.M.: Personal Communication, 1958.

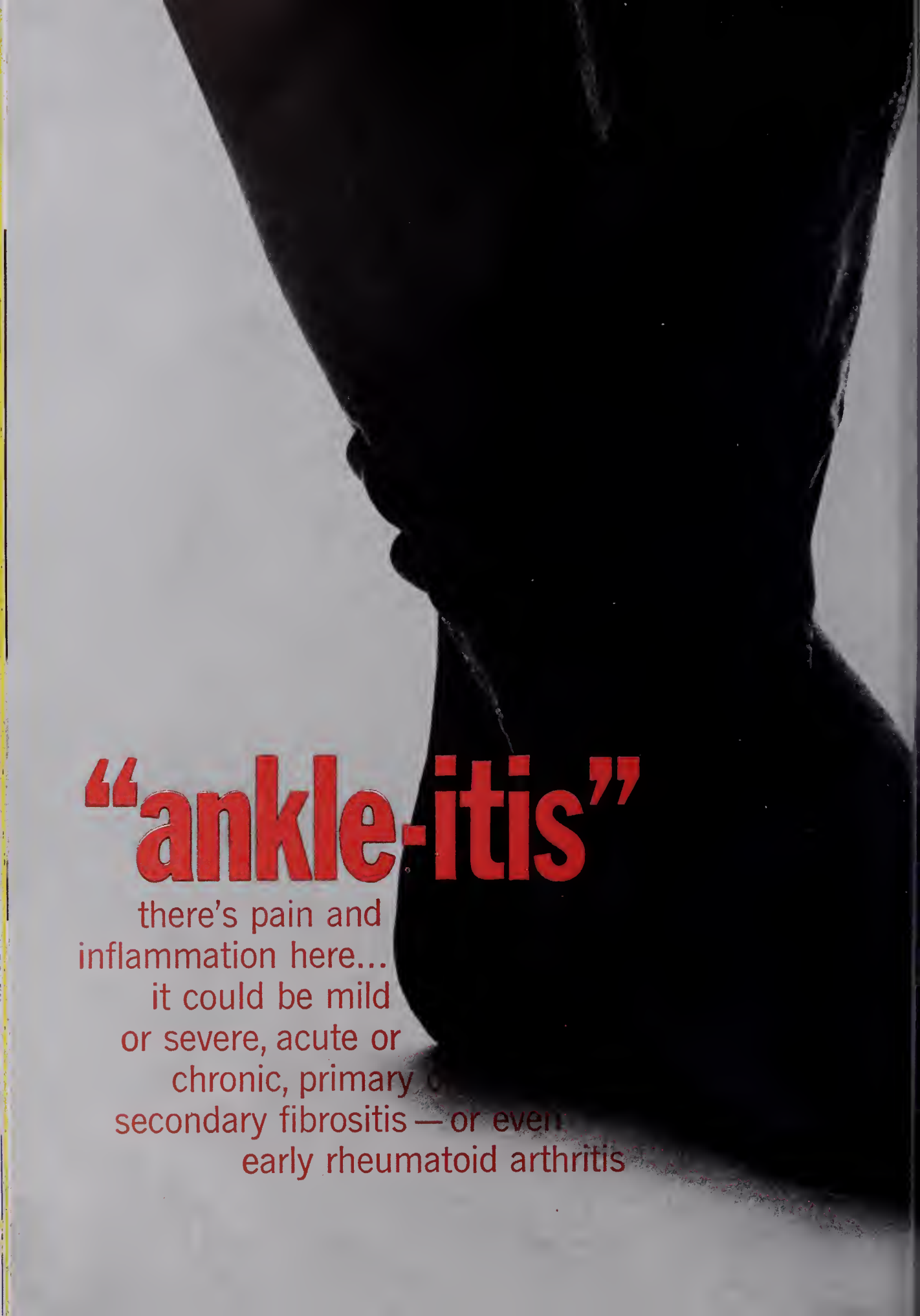
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it could be mild
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more potent and comprehensive treatment than salicylate alone

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subacute or chronic conditions: Initially as above. When satisfactory control is obtained, gradually reduce the daily dosage to minimum effective maintenance level. For best results administer after meals and at bedtime.

precautions: Because SIGMAGEN contains prednisone, the same precautions and contraindications observed with this steroid apply also to the use of SIGMAGEN.



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Composition

METICORTEN® (prednisone)	0.75 mg.
Acetylsalicylic acid	325 mg.
Aluminum hydroxide	75 mg.
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Packaging: SIGMAGEN Tablets, bottles of 100 and 1000.

References: 1. Spies, T. D., et al.: J.A.M.A. 159:645, 1955. 2. Spies, T. D., et al.: Postgrad. Med. 17:1, 1955. 3. Gelli, G., and Della Santa, L.: Minerva Pediat. 7:1456, 1955. 4. Guerra, F.: Fed. Proc. 12:326, 1953. 5. Busse, E. A.: Clin. Med. 2:1105, 1955. 6. Sticker, R. B.: Panel Discussion, Ohio State M. J. 52:1037, 1956.

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PUBLIC HEALTH PAGE

Public Health Page Referral One Twenty-One

RUSSELL E. TEAGUE, M.D.

Commissioner of Health *Commonwealth of Kentucky*

MRS. O, a terminal case of Raynaud's Disease was referred to the health department by Dr. Blank, with the request that assistance be given to ease her remaining days. When the nurse arrived in the home, she found not only Mrs. O an invalid, but also that Mr. O had been bedfast for the past year with arthritis. Both patients were being cared for by an only daugher of 51 years of age.

It was obvious on the first visit that nothing much could be done for Mrs. O except to teach the daughter easier and better ways to care for her parents. Mrs. O expired fourteen days after the first visit. In the meantime, the nurse's attention was also directed toward Mr. O. During the past year he had been fed by the daughter. He was confused, his toilet habits were neglected and his bed was continually untidy.

However, his physical condition did not appear to warrant the demands made upon the daughter. On the second visit a successful effort was made to get Mr. O into a wheel chair and the daughter instructed in the procedures of getting him from bed to wheel chair and back. On succeeding visits, he was always found in the wheel chair in which he spent most of the day. His toilet habits improved during this time. At the end of two months, he was taught how to use a walker.

He is now able to get in and out of bed by himself, dress and undress, go to the table for meals and feed himself. For several years the daughter had contemplated marriage. Following the death of the mother and the improvement in the father's condition, she married and the father continues to live with her.

There is nothing unusual in the case cited above. It is an example of what occurs in many homes throughout the state, where the needs of adequate medical supervision cannot be met. What has actually happened in this home demonstrates that a home care service provided by the country health department, under the instructions of the attending physician, can go far toward relieving the home situation in which there is a long-term illness.

Five Kentucky county health departments in cooperation with local medical societies — Bourbon, Clark, Harrison, Owen, and Scott—have been operating such a program over the past eighteen months. The program opened in Scott County in January 1, 1958, and was gradually developed in the other four during the same year. The purpose of the activity was to demonstrate the county health departments could provide such a service and a the same time maintain the usual health department activities. It was assumed to begin with, that the public health nurse-population ratio would have to be improved. An additional nurse was added to each of the five departments, making this ratio about one nurse for each 4700 unit of population.

Preparatory to the introduction of the program, each nurse was given a brief period of experience with the Louisville Visiting Nurse Association in order to learn just what activities could be successfully carried out in the home. A nutritionist was next acquired who could serve all five counties as a consultant to the nurses in nutritional problems and such special diets as might be prescribed by the physician. Nursing homes in these counties were offered the services of the health department in such special problems as assistance in training attendants, nursing procedures, and special diets.

During the early months, the home care activity was being "played by ear" so to speak and ways to solve certain problems had to be found as the occasion arose. Among these problems was the early cardiovascular accident case and the need for early mobilization. A physical therapist was included in the early plans, but recruitment was unsuccessful. In order to fill the needs until a physical therapist could be acquired, arrangements were made for each nurse to take a two-weeks training course at the Rehabilitation Center, Inc., in the Louisville General Hospital. This enables the nurse to instruct a member of the patient's family in carrying out the exercises prescribed by the physician.

(Continued on page 1283)

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Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
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Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
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ROBAXIN BENEFICIAL IN 92.4% OF SKELETAL MUSCLE SPASM CASES

	NO. PATIENTS	RESPONSE			
		"marked"	moderate	slight	none
Carpenter[1]	33	26	6	1	—
		"pronounced"			
Forsyth[2]	58	37	20	—	1
		"good"			
Lewis[3]	38	25	6	—	7
O'Doherty & Shields[4]	17	"excellent" 14	2	1	0
		"significant"			
Park[5]	30	27	—	2	1
		"gratifying"			
Plumb[6]	60	55	—	—	5
TOTALS	236	184 (78.0%)	34 (14.4%)	4	14

- **Highly potent—and long acting.**[1,2,3]
- **Relatively free of adverse side effects.**[1,2,3,5,6]
- **In ordinary dosage, does not reduce muscle strength or reflex activity.**[1]

REFERENCES: 1. Carpenter, E. B.: Southern M. J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Lewis, W. B.: California Med. 90:26, 1959. 4. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:160, 1958. 5. Park, H. W.: J.A.M.A. 167:168, 1958. 6. Plumb, C. S.: Journal-Lancet 78:531, 1958.

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Public Health Page

(Continued from page 1280)

The success of this venture was apparent from the beginning. It is an adjunct to the physician's services. Since every case cared for must be referred by a physician, a minimum of the physician's time is required, as the nurse reports the condition of the patient to the physician following each visit and at the same time accepts further orders. It is not a demand service, inasmuch as no acute cases are cared for. It is not a service given to a patient indefinitely, because the basic precept of the program is that of instruction in home care. The number and frequency of visits is determined by the physician and the presence of someone in the home who can be taught to give the patient adequate interim care. There is a hard way and an easy way to bathe a patient, change linen, prevent pressure sores, and perform other services for the chronically ill patient. Invariably the nurse finds these services being performed the hard way. She tactfully introduces the easier ways of patient care, and on succeeding visits sees that her instructions are being followed.

It should be emphasized here that this is a home care program and not a home nursing program. It goes beyond home nursing in that services in addition to nursing are provided and the ultimate goal the training of a member of the household to care for the patient. Needless to say, the program may vary from county to county, depending upon the decision of the County Medical Society as to who should be given home care services and the extent and type of procedures to be carried out in the home.

For the amount of care that can be given, for the gratitude of the recipients, for the rehabilitation toward at least a self-care and for the postponement, in many instances, of ultimately becoming public charges, the program is an inexpensive one. And it might be significant that the daughter in the case above, before finally deciding to marry, visited the county health department to seek the advice of the nurse who assisted her in caring for her father and mother!

NEWS ITEMS

Col. Eli Daman, took over as commanding officer of the Louisville Medical Depot on September 30. He succeeds **Col. Louis F. Williams,** commanding officer since 1955, who is retiring. A member of the Medical Service Corps, Colonel Daman commanded a medical depot in the Philippines in World War II.

Morris L. Peyton, M.D., recently located in West Liberty where he is associated with Ralph L. Gullett, M.D., in general practice. Doctor Peyton graduated from the University of Louisville in 1956 and inerned at St. Josephs Infirmary in Louisville. He has just completed a tour of duty with the U. S. Army at Fort Knox's Ireland Army Hospital.

The American College of Allergists Graduate Instructional Course and Annual Congress will be held from February 28 to March 4, 1960, at the Americana Hotel, Bal Harbour, Miami Beach, Fla. For information contact, John D. Gillaspie, M.D., treasurer, 2049 Broadway, Boulder, Colo.

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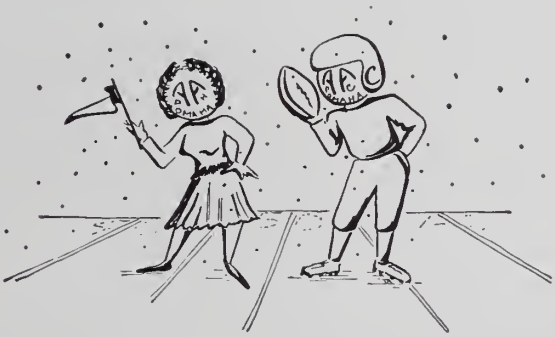
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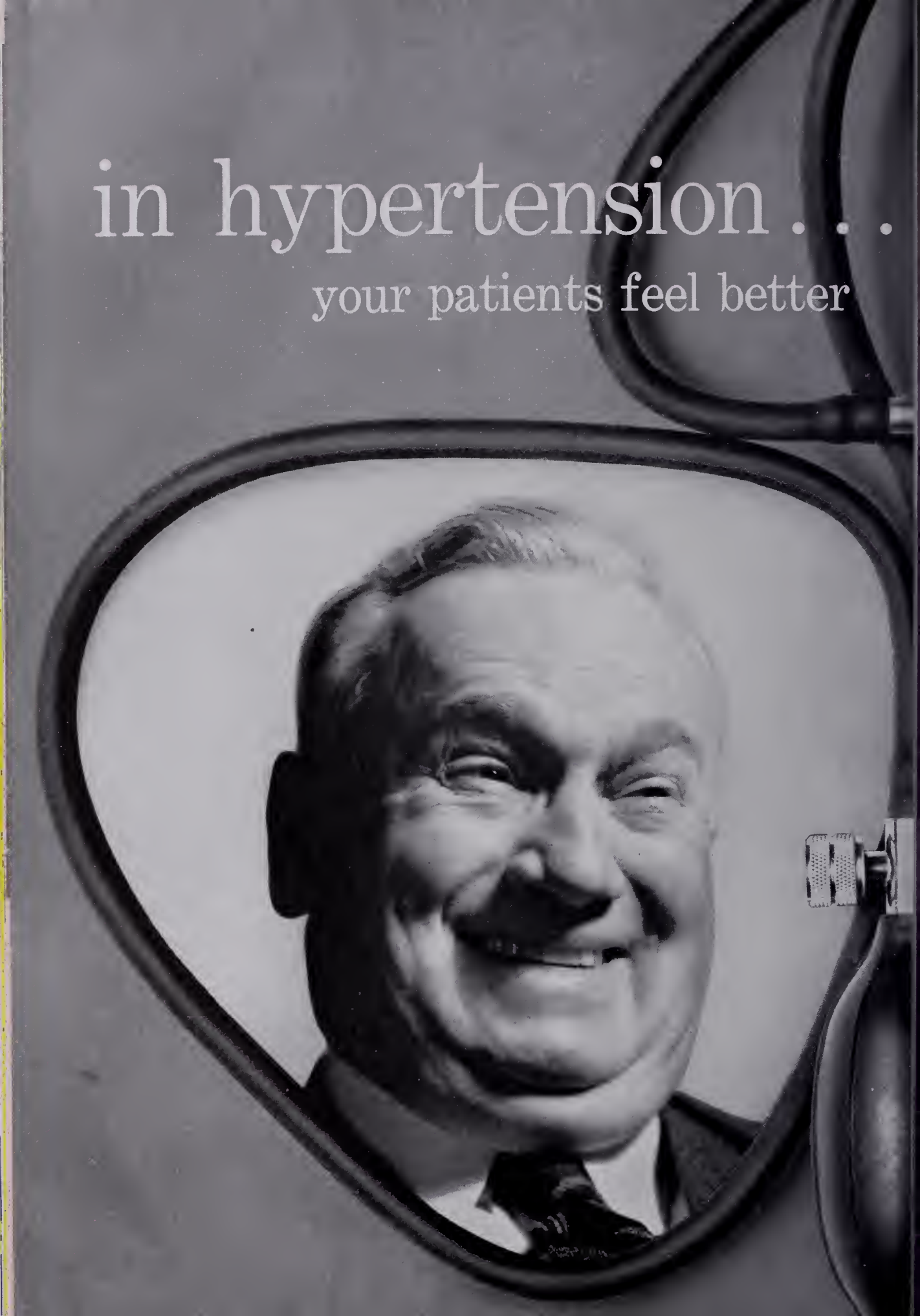
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in hypertension . . .

your patients feel better



and
blood pressure
is controlled
safely and
effectively

The hypertensive under treatment is frequently burdened with side effects of therapy including states of depression, fatigue, and lethargy. He finds little joy left in his life and laughter is almost a forgotten experience.

With RAUTENSIN and RAUVERA, two unique and dependable antihypertensive agents, patients feel better, have a brighter outlook and blood pressure is safely reduced.

in mild hypertension

RAUTENSIN provides smoother antihypertensive action with no sudden rebounds or abrupt declines, and can be given over long periods of time without impairing mental alertness, producing excessive lethargy or drowsiness. When tachycardia is present, RAUTENSIN slows heart rate 10 to 15 per cent. RAUTENSIN is less likely to cause mental depression.[1] The apprehensive hypertensive is calmed, yet side actions are " . . . either completely absent or so mild as to be inconsequential."[2]

RAUTENSIN®

each tablet contains 2 mg. of the purified alseroxylon complex of Rauwolfia serpentina

Dosage: For the first 20 to 30 days, 2 tablets (4 mg.) once daily, at bedtime. Thereafter, a maintenance dose of 1 tablet (2 mg.) daily will suffice for most patients.

in moderate to severe hypertension

RAUVERA produces smooth and steady antihypertensive action which persists over the entire twenty-four hours without peaks and valleys . . . no "saw tooth" effect. Patients show a marked subjective as well as objective improvement with a significant drop in blood pressure, yet with a very low incidence of side effects.[3] Abrupt rise in blood pressure does not occur even when therapy is interrupted.[4] Tolerance does not develop on prolonged administration. Sensitization reactions or postural hypotension do not occur. Headaches, fatigue, insomnia and "heart consciousness" rapidly disappear, leaving the patient feeling well and asymptomatic.

RAUVERA®

each tablet contains 1 mg. of purified alseroxylon complex of Rauwolfia serpentina and 3 mg. alkavervir (Veratrum viride fraction)

Dosage: One tablet 3 or 4 times daily, ideally after meals, at intervals of not less than 4 hours.

1. Moyer, J. H.; Dennis, E., and Ford, R.: Arch. Int. Med. *96*:530, 1955.
2. Terman, L. A.: Illinois M. J. *3*:67, 1957.
3. La Barbera, J. F.: M. Rec. & Ann. *50*:242, 1956.
4. Bendig, A.: New York J. Med. *66*:2523, 1956.

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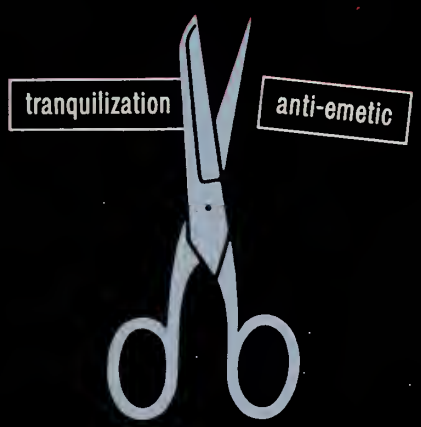
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now potent tranquilizer therapy is safer than ever



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

MELLARIL is virtually free of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

SANDOZ

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis—even when given in quantities far in excess of the usual dosage.

"POVERTY" OF SIDE EFFECTS

"The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects.... In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested. For this reason also it is well tolerated by patients, particularly those who are not hospitalized and who frequently discontinue their medication because of dizziness, sleepiness, increased tension or parkinsonism with other drugs."[2]

NEGLIGIBLE SIDE EFFECTS

"Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent.... Patients forced to interrupt treatment with other phenothiazine derivatives because of parkinsonism or other extrapyramidal symptoms were able to continue therapy with thioridazine without appearance of parkinsonism."[3]

SINGULARLY FREE OF SIDE EFFECTS

"The extrapyramidal syndrome was not encountered in any of its forms. Dizziness and sleepiness responded to a reduction in dosage. Other side effects did not occur.... It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."[4]

ABSENCE OF SIGNIFICANT SIDE EFFECTS

"None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."[1]

MINIMAL SIDE EFFECTS

"Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."[5]

NO JAUNDICE

"No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."[6]



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY "... produced extremely satisfactory results in the broad therapeutic range represented in this series."[3]

POTENT AGENT "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."[4]

MAJOR ADDITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."[1]

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent. . . . It is effective in a variety of psychiatric disorders, including schizophrenic reactions. . . . The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."[6]

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."[7]

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life . . . were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."[8]

"... extremely satisfactory results ..." in a clinical spectrum ranging from minor nervous disorders to severe psychotic disturbances[3]

RESULTS WITH MELLARIL IN 194 PATIENTS[3]

ACUTE PSYCHOTICS	CHRONIC PSYCHOTICS	NEUROTICS
83% satisfactory effect	68% satisfactory effect	57% satisfactory effect
Some cases had complete remission of symptoms. Most were able to return home to useful occupations	Relief of symptoms in cases permitted easier management and a return to a more or less useful life.	Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

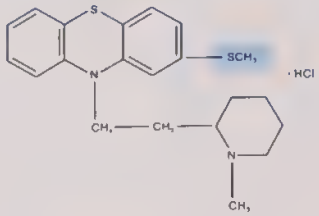
RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS[3]

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	89	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25

Mellaril®
THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels
tranquilization
anti-amatic

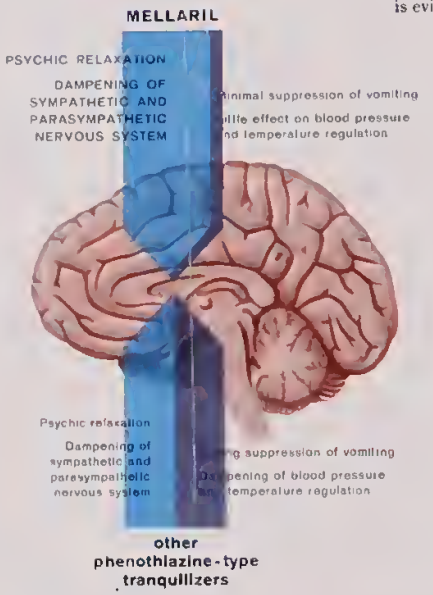
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THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels
anti-amatic

a new advance in tranquilization:
greater specificity of tranquilizing action plus fewer side effects



Of 100 phenothiazines synthesized by Sandoz, Mellaril was selected as the most promising on the basis of extensive evaluation. The presence of a thiomethyl radical (S·CH$_3$) in the position conventionally occupied by a halogen in other phenothiazines is unique and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.





2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy, while achieving psychomotor control in mental and emotional disorders.

5 Virtual freedom from toxic effects — jaundice, photosensitivity, skin eruptions, disturbed body temperature regulation, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety in general office practice, in ambulatory psychiatric out-patient clinics, and in hospitalized patients.

a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric out-patients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered.

Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

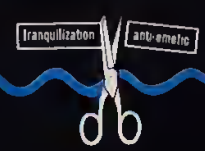
SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

1 Ostfeld, A. M. Scientific Exhibit, American Academy of General Practice, San Francisco, April 6-9, 1959. 2. Kinross-Wright, V. J. Lecture, Clinical Meeting, American Medical Association, Minneapolis, Dec. 4, 1958. 3. Kinross-Wright, V. J.: Scientific Exhibit, Clinical Meeting, American Medical Association, Minneapolis, Dec. 2-5, 1958. 4. Cohen, S.: TP-2L, a new phenothiazine, Am. J. Psychiat. *115*:358, Oct. 1958. 5. Glueck, B.: Scientific Exhibit, American Psychiatric Association, Philadelphia, April 27-May 1, 1959. 6. Hollister, L. E., and Macdonald, B. F.: Presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959. 7. Remy, M.: Schweiz. med. Wchnschr. *88*:1221, Nov. 29, 1958. 8. Freed, S. C., in discussion on Thioridazine (Mellaril) in Psychiatric Patients, Hollister, L. E., and Macdonald, B. F., presented at California Medical Association; Section on Psychiatry, San Francisco, Feb. 25, 1959

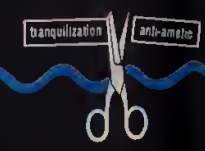
- controls neurotic and psychotic patients with anxiety, apprehension, nervous tension
- virtual absence of jaundice, parkinsonism, photosensitivity, dermatitis
- minimal sedation and drowsiness
- does not mask organic conditions such as brain tumors, intestinal obstruction, etc., because of lack of anti-emetic action
- increased specificity of action results in greater safety at all dosage levels

SANDOZ

Mellaril®
THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels



Mellaril®
THIORIDAZINE HCl
specific, effective tranquilizer • safer at all dosage levels



Ideally Suited for Long-Term Therapy*



just two tablets at bedtime

After full effect one tablet suffices

Rauwiloid®

alseroxylon, 2 mg.

In Hypertension

*Because RAUWILOID provides effective Rauwolfia action virtually free from serious side effects... the smooth therapeutic efficacy of Rauwiloid is associated with a lower incidence of certain unwanted side effects than is reserpine... and with a lower incidence of depression. Tolerance does not develop.

RAUWILOID can be initial therapy for most hypertensive patients... Dosage adjustment is rarely a problem.

When more potent drugs are needed, prescribe one of the *convenient single-tablet combinations*

Rauwiloid®+Veriloid®
alseroxylon 1 mg. and alkavervir 3 mg.

or

Rauwiloid®+Hexamethonium
alseroxylon 1 mg. and hexamethonium chloride dihydrate 250 mg.

Many patients with severe hypertension can be maintained on Rauwiloid alone after desired blood pressure levels are reached with combination medication.

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"Doctor, I get so mad at everyone when I diet."

'Dexamyl' *Spansule* capsules provide single-dose daylong appetite control and an often remarkable mood improvement. A feeling of serene optimism frequently replaces the tension and irritability so characteristic of the dieting patient.

When your overweight patient is listless and lethargic, 'Dexedrine' *Spansule* capsules will, in addition to curbing appetite, provide gentle stimulation.

DEXAMYL* for most overweight patients
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In listless and lethargic overweight patients—**DEXEDRINE†**

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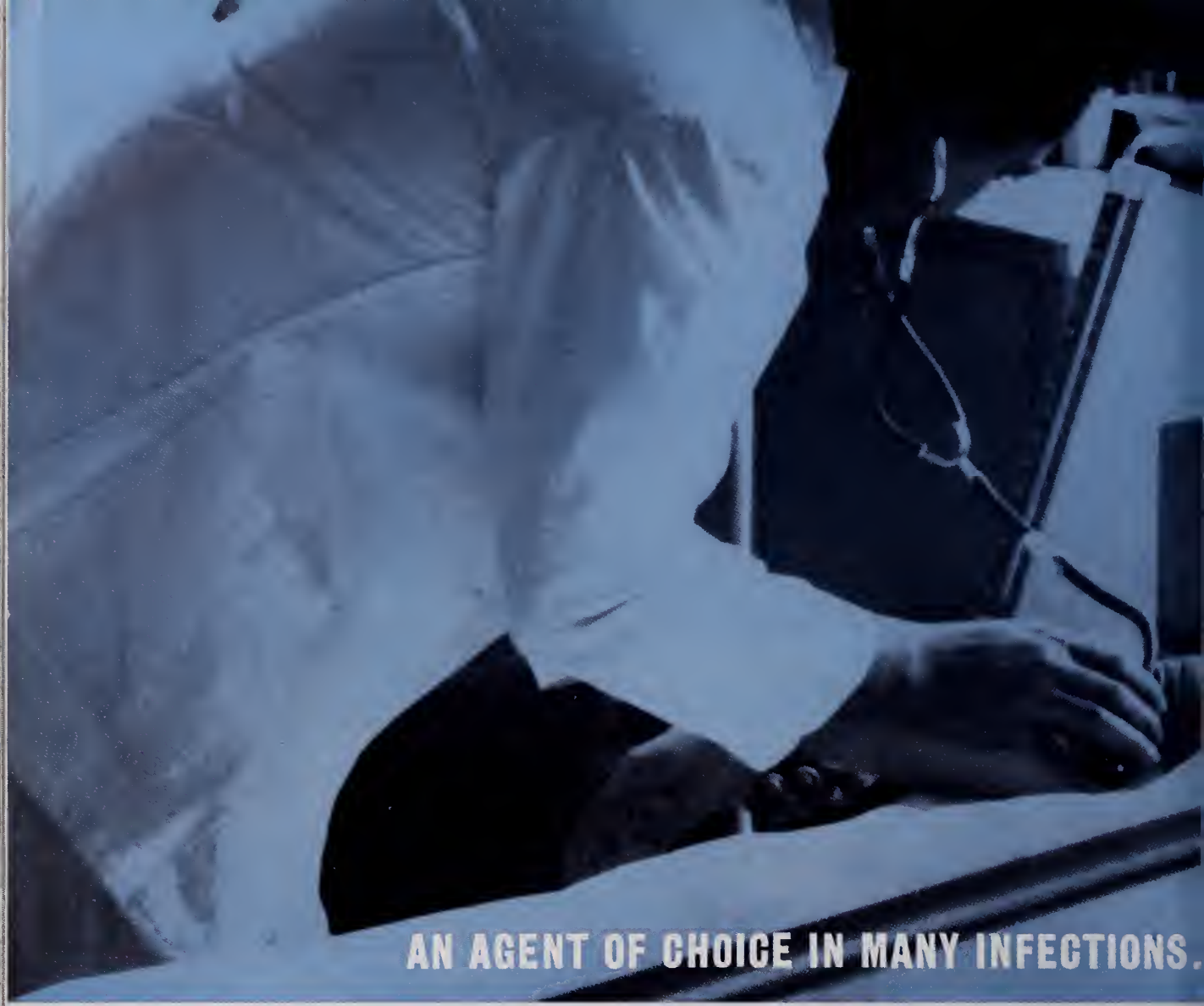
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"In selecting the antibiotic of choice for treating urinary pathogens, *in vitro* testing is essential."[1] Numerous studies[2-9] attest the wide antibacterial activity of CHLOROMYCETIN—"...often effective against organisms which are resistant to the other broad-spectrum antibiotics."[3] For example: "...it often provides a means of controlling infections due to such resistant organisms as *Proteus*."[3]

"*B. proteus* exhibits a greater sensitivity to chloramphenicol than to other antibiotics," according to one investigator.[4] Another reported: "*Proteus* bacilli are often drug resistant, but significant activity against them is exhibited by chloramphenicol...."[5] In the latter study, CHLOROMYCETIN "...showed the greatest activity among the agents tested against *E. coli, A. aerogenes,* and *Proteus* species."[5]

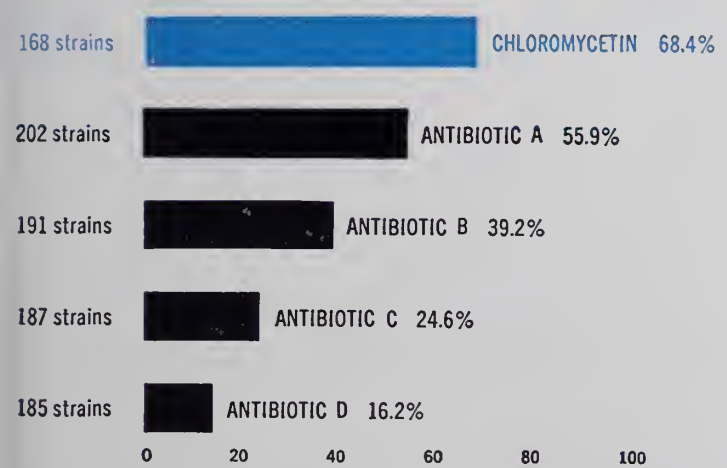
CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES: (1) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 29:159, 1957. (2) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9:38, 1959. (3) Murphy, J. J., & Rattner, W. H.: *J.A.M.A.* 166:616, 1958. (4) Rhoads, P. S.: *Postgrad. Med.* 21:563, 1957. (5) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955. (6) Seneca, H.: *Am. Pract. & Digest Treat.* 10:622, 1959. (7) Hall, W. H.: *M. Clin. North America* 43:191, 1959. (8) Seneca, H., *et al.*: *J. Urol.* 81:324, 1959. (9) Wolfsohn, A. W.: *Connecticut Med.* 22:769, 1958.



IN VITRO SENSITIVITY OF PROTEUS SPECIES TO CHLOROMYCETIN AND TO FOUR OTHER ANTIBIOTICS*



*Adapted from Suter & Ulrich.[2]
These antibiotics were tested by the tube dilution method, using a concentration of 12.5 mcg/ml. The percentages represent the total number of sensitive strains found in five *Proteus* species.

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NOW many more hypertensive patients may have THE FULL BENEFITS OF CORTICOSTEROID THERAPY

Except for one case of mild blood-pressure elevation (150/90) **no hypertension was seen in any of 1500 patients**† as a result of treatment with DECADRON—the new and, on a milligram basis, most potent of all corticosteroids. **Hypertension induced by other steroids diminished or disappeared.**

Thus with DECADRON, hypertension no longer appears to be a contraindication to successful corticosteroid therapy. And the dramatic therapeutic impact of DECADRON was virtually unmarred by diabetogenic or psychic reactions . . . Cushingoid effects were fewer and milder . . . and there were no new or "peculiar" side effects. Moreover, DECADRON helped restore a "natural" sense of well-being.

†Analysis of clinical reports.

Decadron*

DEXAMETHASONE

treats more patients more effectively

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avoid the risk of insoluble, irritating aspirin particles

Chief among the drawbacks to aspirin usage is gastric intolerance. This ranges from mild upset and "heartburn" to severe hemorrhagic gastritis.[1-10] Studies performed in conjunction with gastrectomy[4,5] and gastroscopy[2] have shown insoluble aspirin particles firmly adherent to the gastric mucosa and imbedded between rugae. Reactions varying from mild hyperemia to erosive gastritis have been reported to occur in the areas immediately surrounding these adherent particles.[2,4,5] This is reported to be particularly true in patients with peptic ulcer.[4]

CALURIN is the freely soluble, stable calcium aspirin complex. Its high solubility forestalls gastric irritation or damage



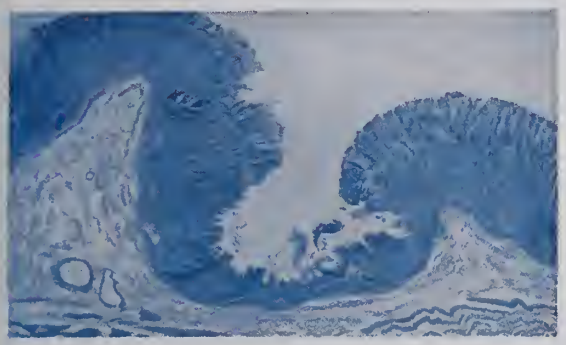
Regular aspirin crystals 24 hours after being mixed into water.



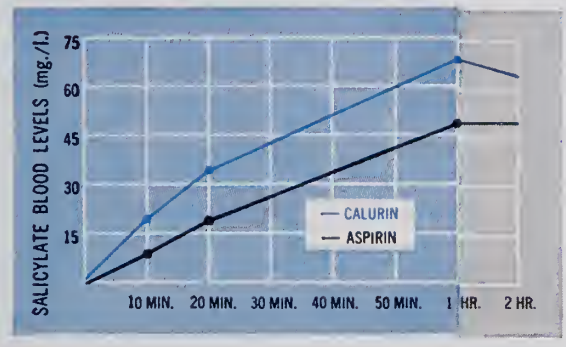
Calurin crystals in solution one minute after being mixed into water.

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYLSALICYLATE-CARBAMIDE



Particle-induced ulceration — section through lesion found in gastrectomy specimen. An aspirin particle was found firmly imbedded in this undermined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.[11]

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

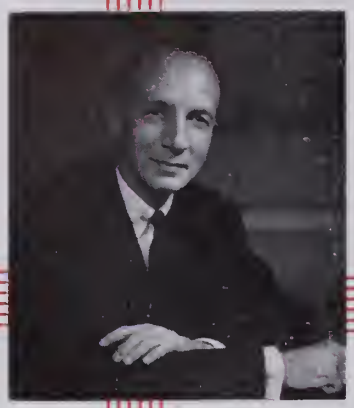
1. High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
2. Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritic effect.
3. Sodium-free — for safer long-term therapy.
4. Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Dosage: Each tablet of Calurin is equivalent to 300 mg. (5 gr.) of acetylsalicylic acid. For relief of pain and fever in adult patients, the usual dose of Calurin is 1 to 3 tablets every 4 hours, as needed; in arthritic states, 2 or 3 tablets 3 or 4 times daily; in rheumatic fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, Brit. M. J. 2:1531, 1955. 2. Douthwaite, A. H., and Lintott, G. A. M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, Lancet 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, Canad. M. A. J. 80:47, 1959. 4. Muir, A., and Cossar, I. A.: Aspirin and ulcer, Brit. M. J. 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, Lancet 1:539, 1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, Gastroenterology 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, New Eng. J. M. 258:213, 1958. 9. Cronk, G. A.: Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid, New Eng. J. M. 258:219, 1958. 10. Editorial: Aspirin plain and buffered, Brit. M. J. 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of acetylsalicylic acid or calcium acetylsalicylate to human subjects, Report submitted to Smith-Dorsey from Dept. of Pharmacology, Geo. Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

*TRADEMARK

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MESSAGE FROM THE PRESIDENT

Implications of the Forand Bill

Being a political approach to a health problem developed by non-medical people, the Forand Bill (HR 4700) would be administered through directives inherent to all government-controlled programs. Proper care for our senior citizens requires the combined and unrestricted efforts of physicians, nurses, hospitals, social workers, community agencies, and the insurance companies. Where flexibility is essential, only rigidity would exist.

Some political abuses and administration wastes would be unavoidable in any program with an estimated budget of two billion dollars for the first and second years. No Federal program exists today in which the budget has not risen rapidly by the year. The overall social security tax is now at 5% and is scheduled to reach 9% in the years ahead. The Forand Bill would be financed by increasing the current 5% social security tax.

A nationalized program of this type would alter the patient-physician relationship as it exists today. The patient would be restricted in his or her choice of physician, hospital, or nursing home to those under contract to the Federal government. Only in emergencies does a freedom of choice as to physician and hospital exist.

An agency of the Federal government would administer this program and determine the type of care to be provided. It would set fees for physicians and nurses, and charges for hospitals and nursing homes.

Voluntary health insurance would soon be washed away. Once the principle that the Federal government is responsible for one segment of our senior citizens is established, its extension to cover all of our senior citizens would be automatic. And just as the principle is lengthened in width, just so would it sink in depth, until it should embrace all the people. The cost of such a complete program is both unthinkable and incomprehensible. It could well destroy the fiscal soundness of the social security system.

The Forand Bill, now in the Ways and Means Committee of the House in Congress, will be reported out during 1960 for vote by that body. It is vital that these facts and the implications of these facts be widely disseminated amongst the individual citizens, whose votes create and whose opinions influence the lawmakers. The creation of a favorable public and political climate on any issue requires time. And time, already limited, grows shorter with the passing of each day.

These facts and the implications of these facts must be loudly broadcast or the voting public will not hear and so can not answer.

Louis Abell Jr.



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Lysine-Vitamins Lederle

with iron Syrup

for the undersized underweight child

build appetite

with
B complex
vitamins

prevent nutritional anemia

with ferric pyrophosphate, a form of iron exceptionally well-tolerated

in taste-tempting cherry flavor

Average dosage, 1 teaspoonful (5 cc.) contains:

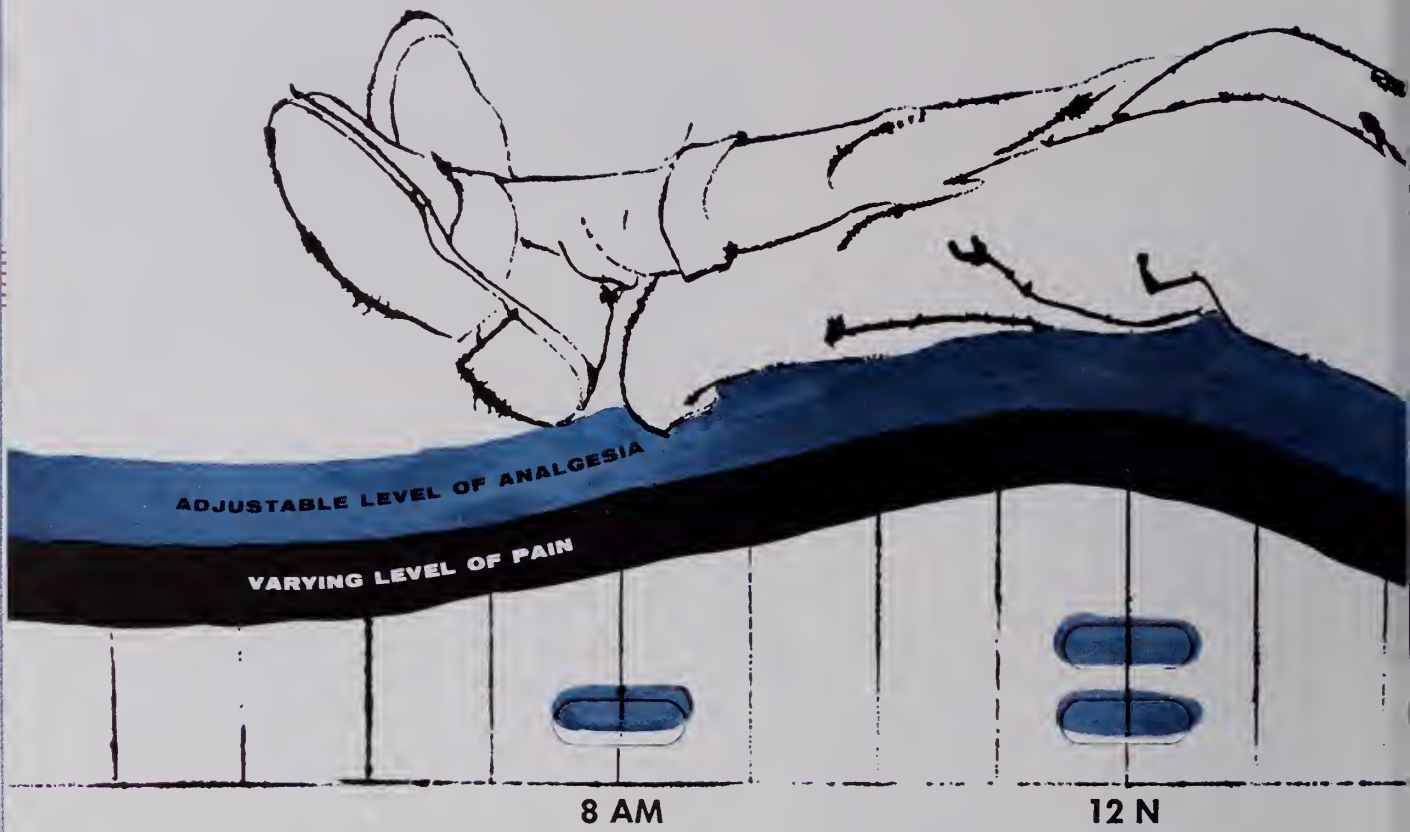
l-Lysine HCl	300 mg.
Vitamin B_{12} Crystalline	25 mcgm.
Thiamine HCl (B_1)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Ferric Pyrophosphate (Soluble)	250 mg.
Iron (as Ferric Pyrophosphate)	30 mg.
Sorbitol	3.5 Gm.
Alcohol	75%

Bottles of 4 and 16 fl. oz.

promote protein uptake

with the potentiating effect of l-Lysine on low-grade protein foods

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keep all patients* pain-free at all times

- with the proper potency to match pain intensity
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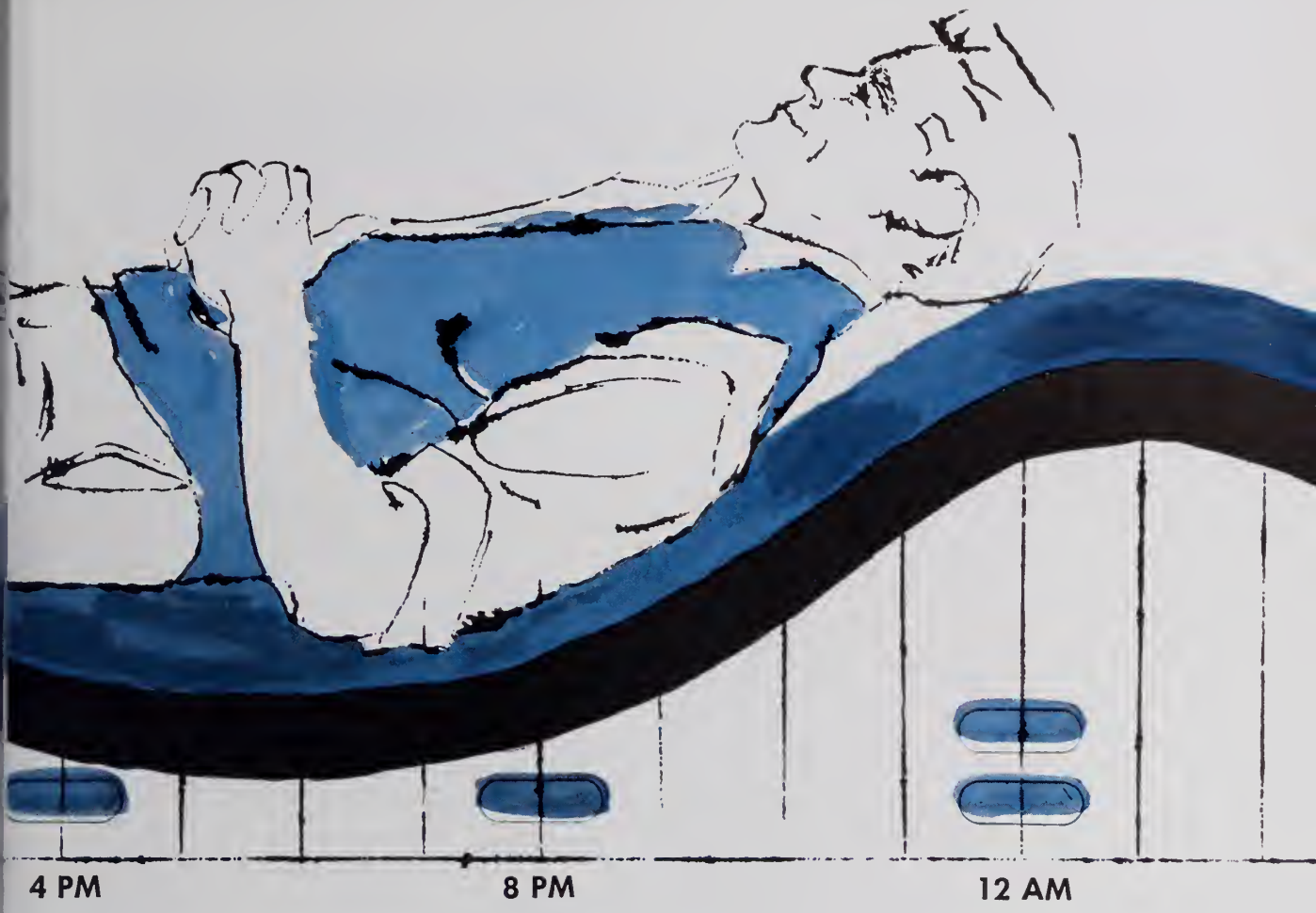
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*except those for whom recourse to morphine is inescapable.

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Phenaphen and Phenaphen with Codeine provide
a wide range of analgesia, plus complete dosage flexibility,
to match varying pain requirements.

Yours to prescribe:

The **right** dose of the **right** potency at the **right** time.

Phenaphen

Basic non-narcotic formula

For mild to moderate pain

Each capsule contains:

Phenacetin (3 gr.)	194.0 mg.
Acetylsalicylic acid (2½ gr.)	162.0 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

greater antihypertensive effect...fewer side effects

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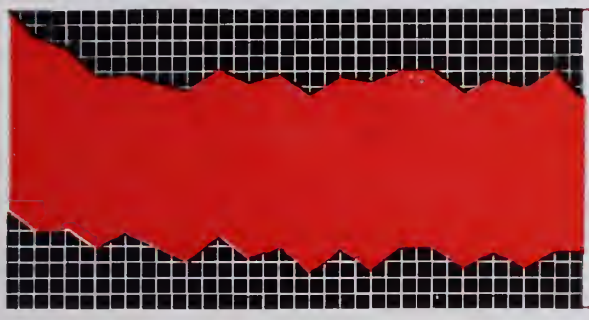
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HYDROCHLOROTHIAZIDE
antihypertensive

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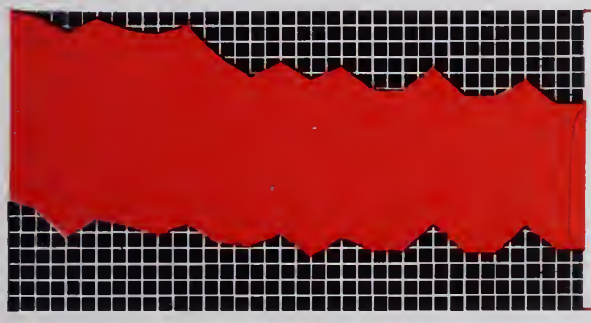
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antihypertensive-tranquilizer



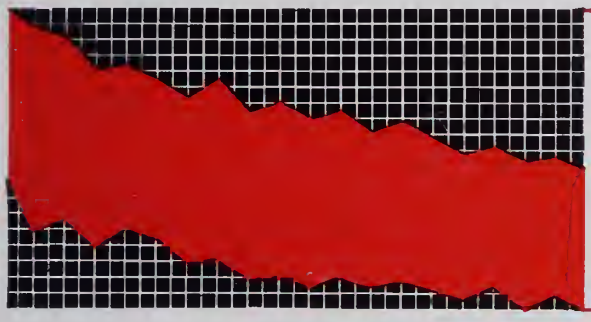
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HYDRODIURIL alone



RESERPINE alone



HYDROPRES

much more effective than either of its components alone

- Effective by itself in a majority of patients. Provides smooth, more trouble-free management of hypertension.
- Since HYDRODIURIL and reserpine potentiate each other, the required dosage of each is lower when given together as HYDROPRES than when either is given alone.
- HYDROPRES provides the needed and valuable tranquilizing effect of reserpine. Lower dosage may reduce such side effects of reserpine as excessive sedation and depression.
- Arrest or reversal of organic changes of hypertension may occur.
- Headache, dizziness, palpitations and tachycardia are usually promptly relieved. Anginal pain may be reduced in incidence and severity.
- With HYDROPRES, dietary salt may be liberalized.
- Convenient, controlled dosage.

HYDROPRES-25

25 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one to four times a day.

HYDROPRES-50

50 mg. HYDRODIURIL, 0.125 mg. reserpine.
One tablet one or two times a day.

If the patient is receiving ganglion blocking drugs or hydralazine, their dosage must be cut in half when HYDROPRES is added.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

*HYDRODIURIL AND HYDROPRES ARE TRADEMARKS OF MERCK & CO., INC.

when a tranquilizer is warranted...

Tentone



The extended usefulness of TENTONE is readily apparent

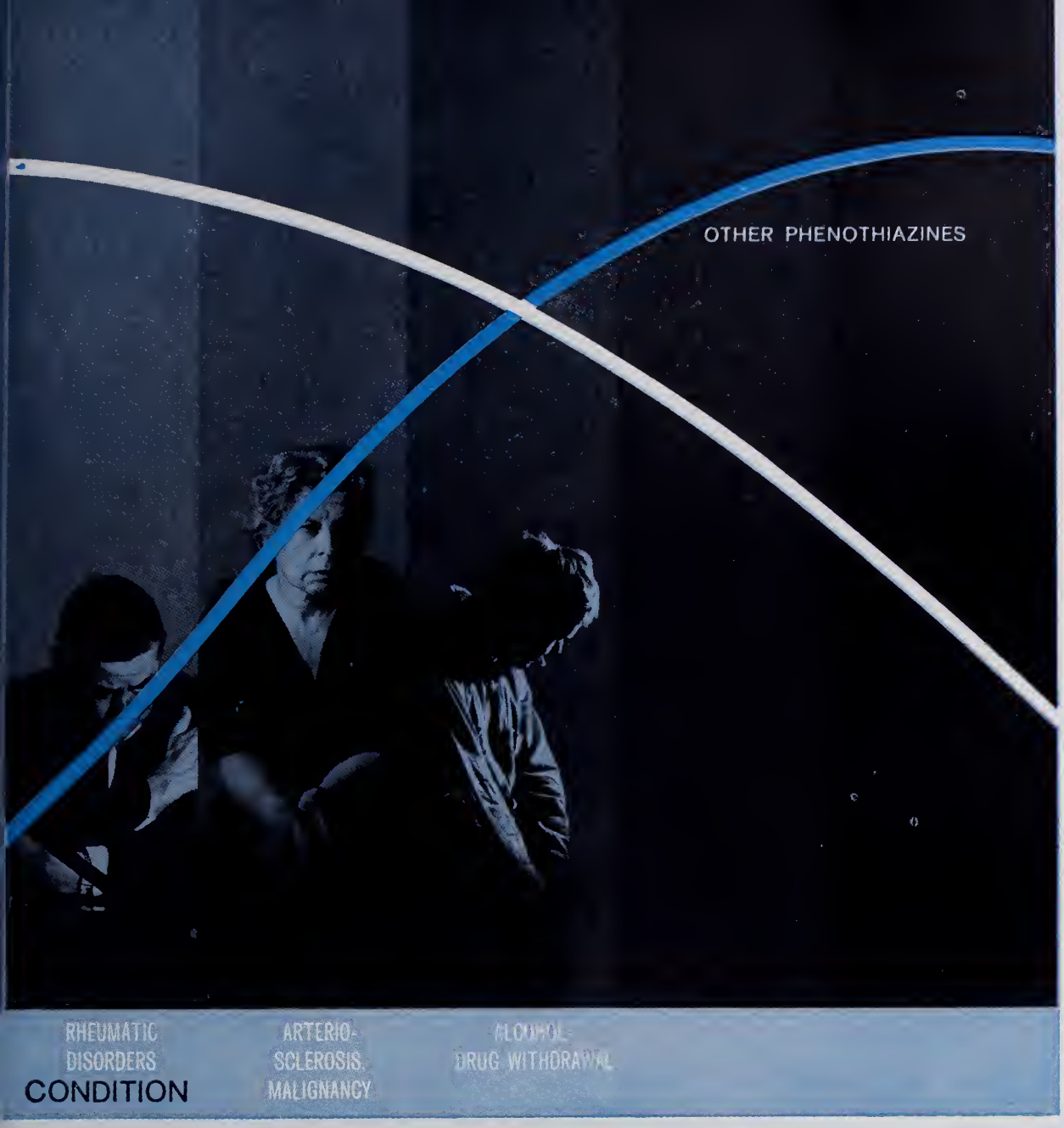
TENTONE® Methoxypromazine Maleate is a new, distinctive phenothiazine...highly active ...for general use in mild and moderate emotional and psychosomatic disorders.

TENTONE elicits a striking, positive calming response[1,2]...with marked reduction of psychic disorientation, and low risk of blood, liver or other organic toxicity and intolerance.[1-4]

TENTONE parallels the weaker ataractics in low incidence of side effects. Freedom from induced depression is apparently even greater.[5]

TENTONE provides a broadly adaptable dosage range (30 to 500 mg. daily) to permit maximum control in cases of varying severity.

TENTONE is also indicated to relieve emotional stress in surgical, obstetric and other hospitalized patients.



Dosage: Mild to moderate cases—average starting dose, one 10 mg. or one 25 mg. tablet three or four times daily. *Moderate to severe*—average starting dose, one 50 mg. tablet four times daily. *Supplied:* 10 mg., 25 mg., and 50 mg. tablets.

1. Bodi, T., and Levy, H.: Clinical report, cited with permission. 2. Wetzler, R. A., and Phillips, R. M.: Clinical report, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.: Am. J. Psychiat.* 115:939 (April) 1959. 5. Turvey, S. E. C.: Clinical report, cited with permission.

Tentone

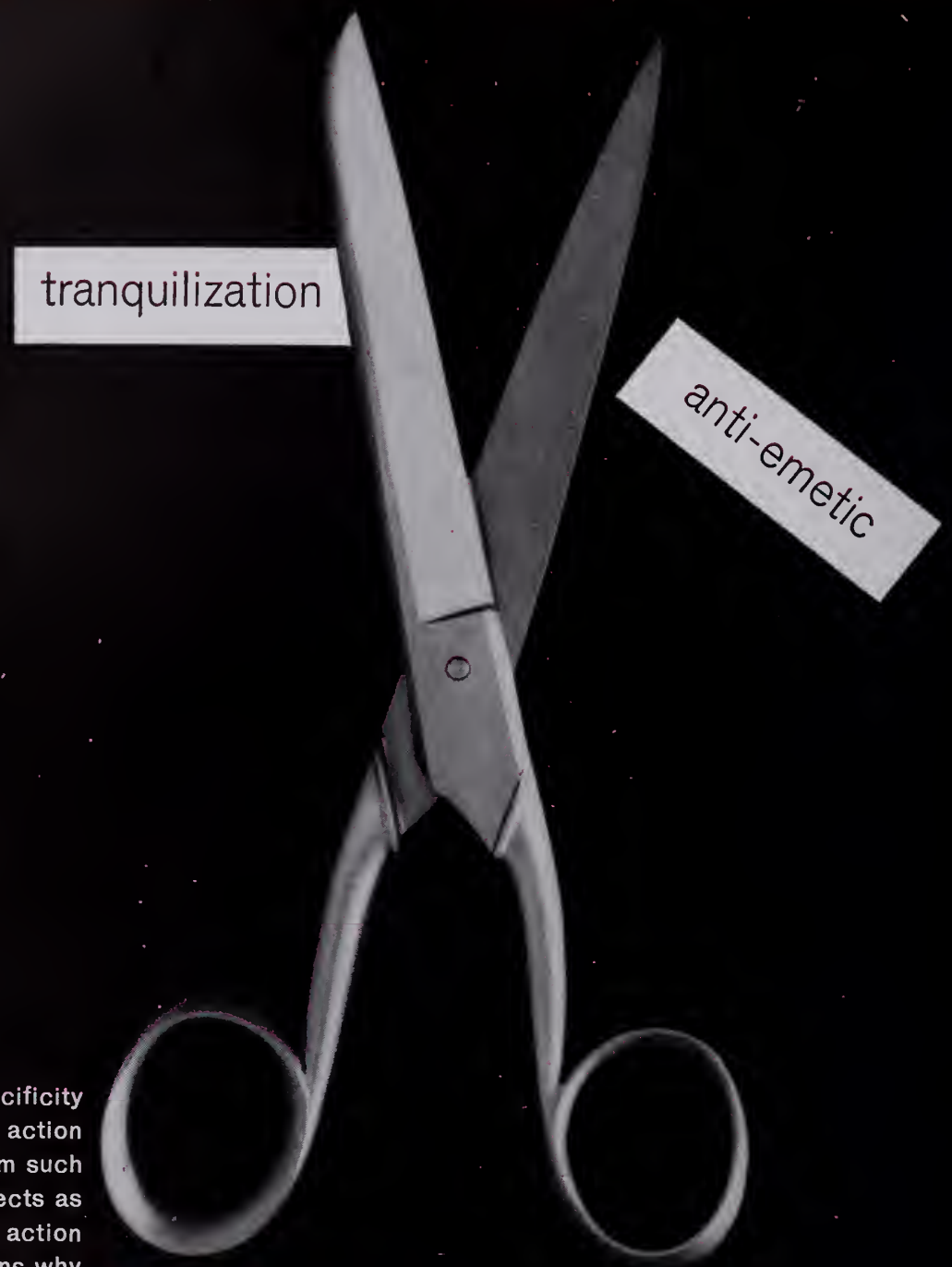
Methoxypromazine Maleate

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NOW... SAFER, EFFECTIVE TRANQUILIZER THERAPY



greater specificity of tranquilizing action —divorced from such "diffuse" effects as anti-emetic action —explains why

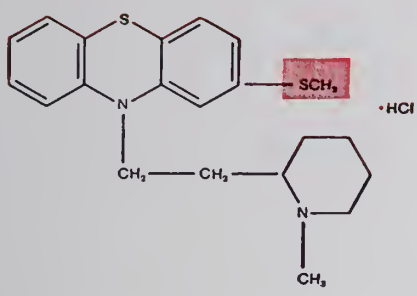
Mellaril®

THIORIDAZINE HCl

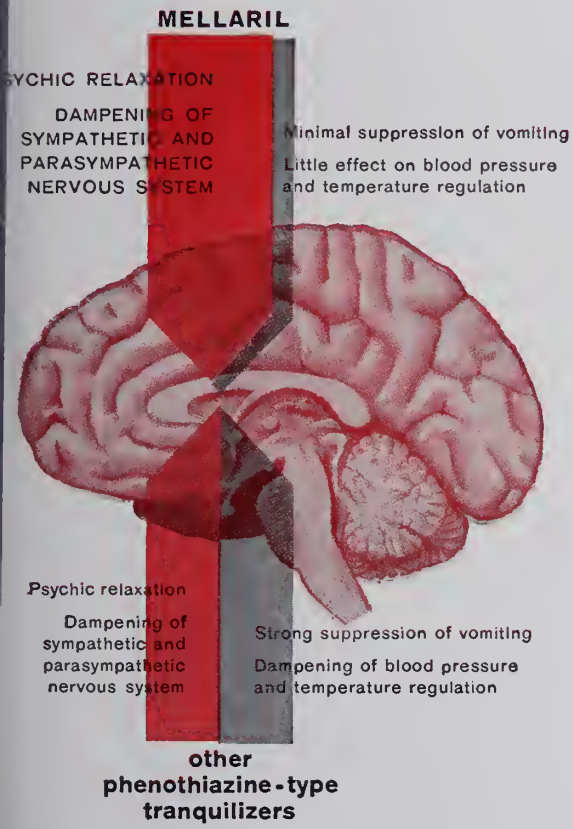
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines.... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

new advance in tranquilization:
reater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S-CH_3) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

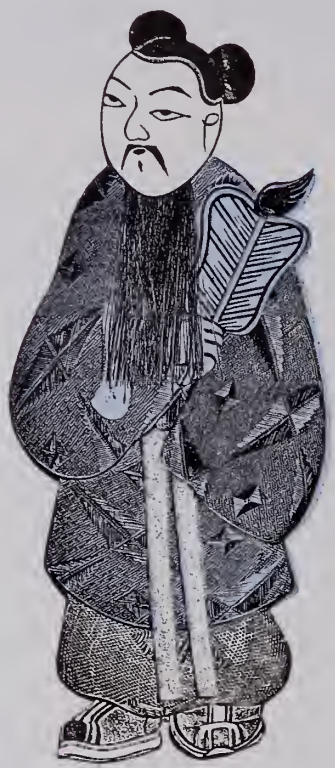
INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

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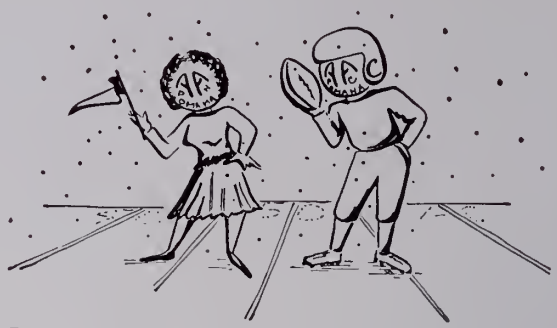
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Lederle introduces a masterpiece of antibiotic design

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Strikingly enhances the traditional advantages of broad-spectrum antibiotics...

for greater patient-physician benefit

DECLOMYCIN is a unique fermentation product of a strain of *Streptomyces aureofaciens*—the parent organism of AUREOMYCIN®* and ACHROMYCIN.®†

DECLOMYCIN singularly achieves:

- far greater antibiotic activity with far less drug
- greater stability in body media
- unrelenting peak activity throughout therapy
- "extra-day" protection through sustained activity

DECLOMYCIN retains:

- unsurpassed broad-spectrum range of activity
- rapid activity
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**Chlortetracycline Lederle* †*Tetracycline Lederle*

DECLO

Demethylchlortetracycline Lederle

Far greater antibiotic activity with far less antibiotic

Milligram for Milligram, DECLOMYCIN exhibits 2 to 4 times the clinical potency (inhibitory action) of tetracycline against susceptible organisms. Thus, DECLOMYCIN has the advantage of providing significantly higher serum *activity* levels with significantly reduced drug intake.* [1,3,5]

Actually, DECLOMYCIN demonstrates the highest ratio of prolonged activity level to daily milligram intake of any known broad-spectrum antibiotic. Reduction of milligram intake of drug reduces hazards of related physical effect on intestinal mucosa or interaction with gastrointestinal contents.

*Activity level is a far more meaningful basis of comparison than quantitative blood levels, as Hirsch and Finland note. Action upon pathogens is the ultimate value.[1]

MYCIN



Unrelenting peak antimicrobial attack throughout therapy

The high level of DECLOMYCIN activity is uniquely sustained. It is not just an initial phenomenon but is constant—maintained on each day of treatment and between doses—without noticeable diminution of intensity. Peak-and-valley control is eliminated, favoring continuous suppression of pathogens and consequent improvement.

This DECLOMYCIN constant is achieved through remarkably greater stability in body fluids,[2,4,6] resistance to degradation[6] and a low rate of renal clearance[4,5]—all supporting antibiotic activity for extended periods.

DECLO

demethylchlortetracycline Lederle

"Extra-day" activity for security against relapse

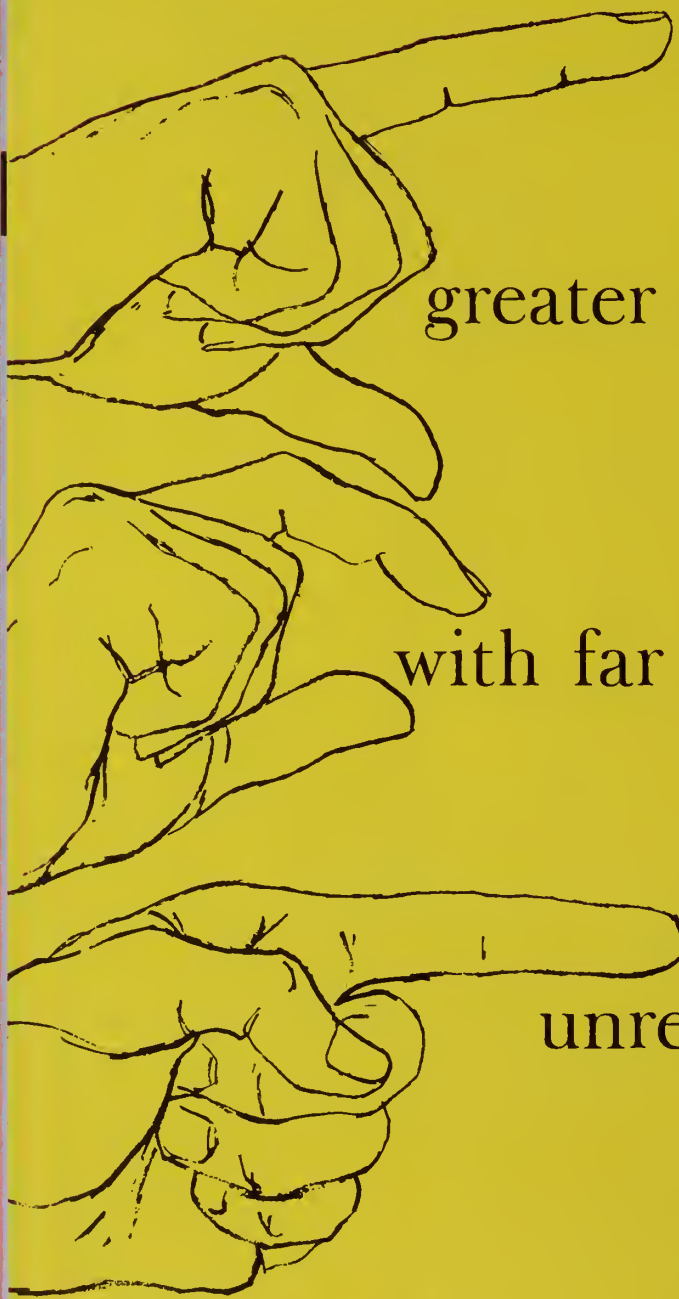
DECLOMYCIN maintains significant antibacterial activity for one to two days after discontinuance of dosage[1]—a major distinction from other antibiotics. Previous drugs have declined abruptly in activity following withdrawal.

DECLOMYCIN thus gives the patient an unusual degree of protection against resurgence of the primary infection, and against secondary infection... sequelae not infrequently encountered and often resembling a "resistance problem." Consequently, reinstitution of therapy or a change in therapy should rarely be necessary.

MYCIN



A masterpiece of



greater antibiotic activity

with far less antibiotic intake

unrelenting peak attack

—enhancing the unsurpassed features of tetracycline . . . for greater physician-patient benefits

DECLO

Demethylchlortetracycline Lederle

antibiotic design

plus
"extra-
day"
activity

FOR PROTECTION
AGAINST
RELAPSE



MYCIN

A major contribution of Lederle research



in the distinctive dry-filled duotone capsule

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Demethylchlortetracycline Lederle

available as:

DECLOMYCIN Capsules, 150 mg.
Adult dosage: 1 capsule four times daily.
Pediatric Drops, 60 mg. per cc.
Bottles of 10 cc. with dropper.
Oral Suspension, 75 mg. per 5 cc. tsp.

1. Hirsch, H. A., and Finland, M.: Antibacterial Activity Of Serum Of Normal Subjects After Oral Doses of Demethylchlortetracycline, Chlortetracycline and Oxytetracycline. *New England J. Med.* 260:1099 (May 28) 1959. 2. Hirsch, H. A., Kunin, C. M., and Finland, M.: Demethylchlortetracycline – A New And More Stable Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Activity. To be published. 3. Lichter, E. A., and Sobel, S.: The Distribution Of Oral Demethylchlortetracycline In Healthy Volunteers And In Patients Under Treatment For Various Infections. To be published. 4. Kunin, C. M., Dornbush, A. C. and Finland, M.: Distribution And Excretion Of Four Tetracycline Analogues In Normal Young Men. To be published. 5. Kunin, C. M., and Finland, M.: Demethylchlortetracycline: New Tetracycline Antibiotic That Yields Greater and More Sustained Antibacterial Capacity. *New England J. Med.* 259:999 (Nov. 28) 1958. 6. Sweeney, W. M.; Hardy, S. M.; Dornbush, A. C., and Ruegsegger, J. M.: Demethylchlortetracycline: A Clinical Comparison of A New Antibiotic with Chlortetracycline and Tetracycline. *Antibiotics & Chemotherapy* 9:13 (Jan.) 1959.

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for that all-important first dose of broad-spectrum antibiotic therapy

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brand of oxytetracycline

INTRAMUSCULAR SOLUTION



Initiation of therapy in *minutes after diagnosis* with new, ready-to-inject Terramycin Intramuscular Solution provides maximum, sustained absorption of potent broad-spectrum activity.

...and for continued, compatible, coordinated therapy

COSA-TERRAMYCIN®
oxytetracycline with glucosamine

CAPSULES

Continuation with oral Cosa-Terramycin every six hours will provide highly effective antibacterial serum and tissue levels for prompt infection control.

The unsurpassed record of clinical effectiveness and safety established for Terramycin is your guide to successful antibiotic therapy.

Supply:
*Terramycin Intramuscular Solution**
100 mg./2 cc. ampules
250 mg./2 cc. ampules

Cosa-Terramycin Capsules
125 mg. and 250 mg.

Cosa-Terramycin is also available as:
Cosa-Terramycin Oral Suspension — peach flavored, 125 mg./5 cc., 2 oz. bottle
Cosa-Terramycin Pediatric Drops — peach flavored, 5 mg./drop (100 mg./cc.), 10 cc. bottle with plastic calibrated dropper

Complete information on Terramycin Intramuscular Solution and Cosa-Terramycin oral forms is available through your Pfizer Representative or the Medical Department, Pfizer Laboratories.

*Contains 2% Xylocaine® (lidocaine), trademark of Astra Pharmaceutical Products, Inc.

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THE INSURANCE PAGE*

Fears Not Justified – Says Northeast Kentucky Service Plan Satisfactory to Both Physician and Patient

SOCIO-ECONOMIC changes are as inevitable as time itself and those who fail to accept this truth can hope only to be defeated and soon forgotten. Such can be the case with our system of medical practice, and in some cases untra conservatism mistaken for rugged individualism has left us the loser.

This may happen again if we do not consider very carefully the outcome of not accepting some form of service contract. For sake of clarity, a service contract is one in which the participating physician agrees to a fixed charge for a given service, providing the policy holder purchases a given contract.

Part Service, Part Indemnity

Fortunately in Blue Shield we can find a carrier who will write a contract, part service and part indemnity, with the fee or indemnity schedule being set by the representatives chosen by the participating physicians themselves. Fortunate also is our position of opportunity in which we can keep pace with social and economic changes without sacrificing any of the basic principles for which medicine has so long stood and for which it still stands.

We in Northeastern Kentucky have lived and worked under a combined type of Blue Shield contract for several years. It is a service contract for the lower income groups and an indemnity contract to the higher income groups. Both the patients and participating physicians have been happy with the plan. Our own chosen representatives worked out the fee and indemnity schedule, subject to our approval. Our elected representatives decide on special consideration cases and adjust differences, of which there have been very few. We have yet to note any effort to fix fees for our indemnity groups and we, ourselves, fixed the schedule for the low income group.

Misrepresentations Rare

Misrepresentation by patients of their income and therefore their eligibility to claim service benefits has been exceedingly rare, and we have every reason to believe it would be quite rare in other localities of the state.

We expected considerable misunderstanding as to how the combined service and indemnity contracts would work, with particular worry as to reactions when an additional charge would be added to the indemnity schedule. We were amazed at how simple it was in almost every case. Now the usual procedure is for the patient to ask how much the additional charge will be or will his insurance care for our charge, rather than the blunt statement that he has insurance to pay our fees. A short course given to office secretaries will cure most any of the rare difficulties that will arise.

Physicians Set Stipends

Adequacy of stipulated payments would be questioned by some. These fixed stipends in our experience are certainly as high as one in the low income groups can afford to pay and can be altered from time to time as the cost of living varies. This will be done in Blue Shield by the physicians themselves, and we know of no other insurance carrier in such a favorable position.

The adoption of a service contract for the low income group is in keeping with the concept of medicine, which is to provide quality care at a price the patient can afford. There is nothing wrong with helping people budget for their care, especially when that third party is our own organization.

Woodrow Wilson spoke to the effect that we have one life to live and one death to die. If we die without sacrifice and live without a goal, we have lived and died in vain.

Clyde C. Sparks, M.D., Ashland

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* *In order that all members of the Kentucky State Medical Association might have more information on the advantages and disadvantages of the proposal that the Kentucky Physicians Mutual (Kentucky's Blue Shield Plan) offer service-type coverage, the Insurance Page Editor has been asked by the KSMA Advisory Commission to Blue Shield to present an equal amount of space in the same issue of The Journal to proponents and opponents of this proposal. Clyde C. Sparks, M.D., Ashland, former KSMA president, was asked to write the "pro" page, and Coleman C. Johnston, M.D., and William K. Massie, M.D., Lexington, members of the Board of Directors of K. P. M., wrote the "con" page. We are grateful for the contributions these members have made — The Insurance Page Editor.*

THE INSURANCE PAGE*

Shall Kentucky Physicians Mutual Operate Under An Indemnity (Partial Coverage) Or Service (Total Coverage) Basis?

THIS is a decision to be made by the physicians of Kentucky. The following is a statement made by two members of the board of Kentucky Physicians Mutual (K.P.M.) to help acquaint each physician with the problem at hand.

The objective of Kentucky Physicians Mutual (K.P.M.) is to relieve the financial strain on low income groups for medical care. Kentucky Physicians Mutual influence has (1) by competition kept all insurance rates for medical care realistically low; (2) encouraged a widening spectra of insurance coverage; (3) demonstrated to the people of Kentucky that their physicians have taken a firm stand against the socialization of medicine or any subtle effort to attain this end.

The certificates sold by Kentucky Physicians Mutual differ from other insurance policies sold within the state in that (1) the low overhead resultant from its non-profit, non-taxable status is passed on to the insuree; (2) it remains in force until dropped by the insuree, even when the insuree is separated from the group under which he became eligible; (3) it does *not* reward the insuree by lower rates for non-usage (good health). It is this third factor which allows the commercial insurance company to provide a far greater variety of insurance coverage.

Should a service plan be offered, the present idemnity rates would require a considerable increase to allow for a more realistic total coverage fee to the physician. Therefore, good risks or so-called "blue chip" policy holders would pay considerably more for a service infrequently required. In the low income groups many physicians already accept the surgical fees offered by the idemnity plan as full payment for service rendered. Therefore, they, too, would have to pay an increase in premium for the same service.

It is said that a Blue Shield service plan on a national scale would permit broad contracts with labor and management. Is it, however, logical to assume that a given service in all communities, large or small, irrespective of variance in current overhead expenses, and the proficiency of the physician would be acceptable?

No other insurance plan can sell a service policy, because only a plan self-imposed by physicians can sell a physician's services. It has been concluded that this would make a K.P.M. policy more salable. This is subject to some question. However, does the control of an individual physician's fees by a group of physicians (Board of K.P.M.), rather than a lay organization, make the imposition more palatable, or the socialistic trend less reprehensible?

K.P.M. must have the support of a considerable majority of the physicians within the state to honor any service plan they might sell. Remember, if they had already sold our services, what would happen if you renege on your responsibility to serve as a participating physician? Is not the present influence of K.P.M. in the insurance industry too valuable to risk losing?

An indemnity plan requires no added expenditure for administration and no limitation to any participating group. The offering of a service plan, however, would require the sale of several different policies and the publishing of lists of participating physicians. The eligibility of the various insurees cannot be accepted as a responsibility of the company whose interest is merely that of selling insurance. In the final analysis it is the physician who must either question the veracity of his patient, or ignore any obvious falsification of income and thus encourage such practices. To be of any practical value, at least three policies for three income brackets must be provided.

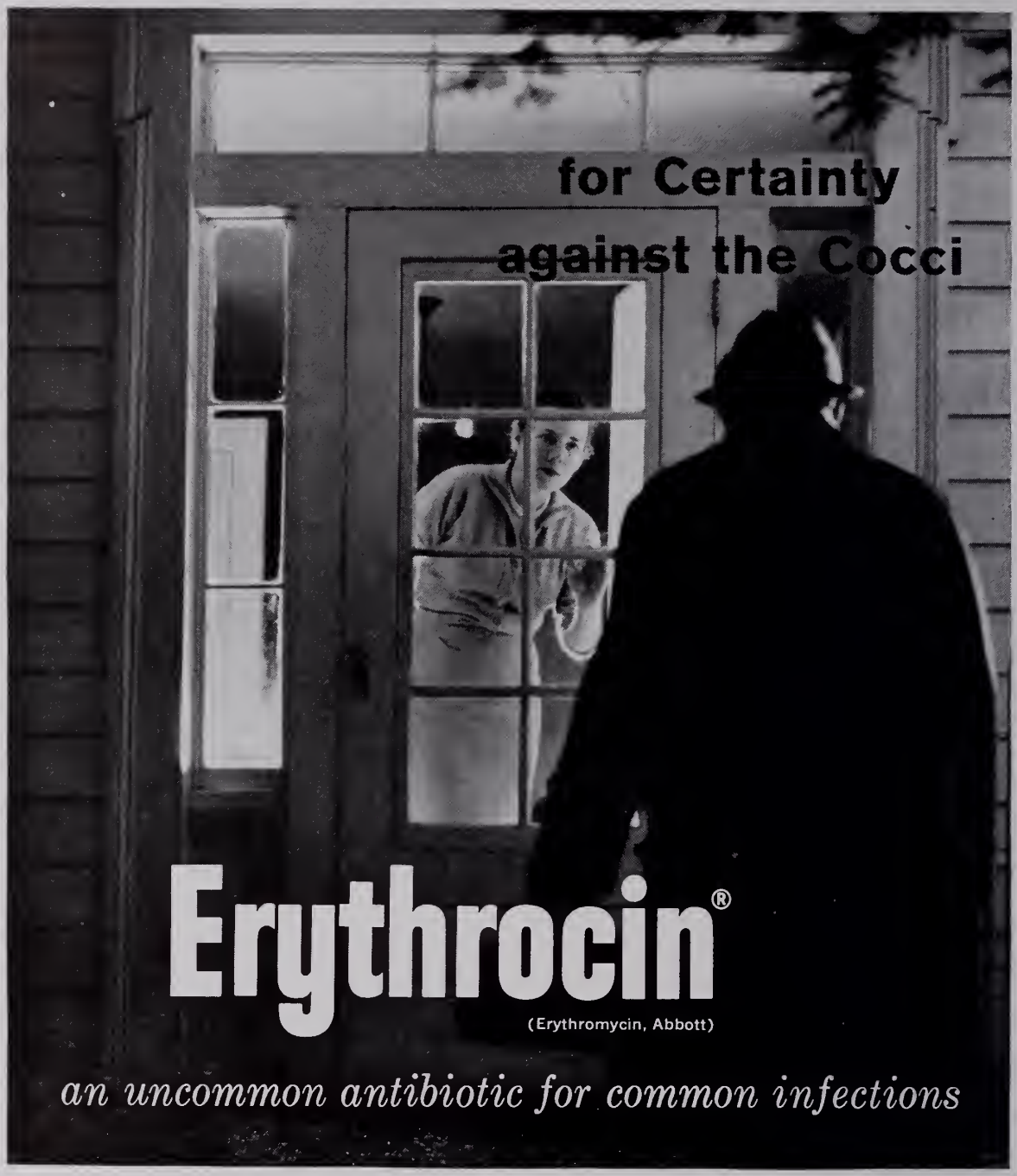
Kentucky Physicians Mutual has estimated that $7,500 for a family would constitute the top bracket for eligibility to a service plan. This would include, however, approximately 90 per cent of Kentucky families. Assuming the widespread sale of the plan, physicians in some communities would have their entire practice regulated by the K.P.M. board.

Acceptance of a service plan by K.P.M. would tend to set the fees for services outside the plan. A self-imposed control by physicians would certainly stimulate other organizations to emulate the procedure with resulting increasing control of fees from other sources. A physician, having given acquiescence to such self-imposed control, would find his objections to government control less convincing.

In basic principle, then, we the physicians of Kentucky must accept as self-evident the basic honesty of our colleagues *(but be willing to prosecute any acts to the contrary)* and their right to regulate their own fees wisely and in the keeping of free enterprise, OR admit that a given professional service has a price regardless of when, where, and by whom it is rendered, and that we must accept the inviolate judgment of a third party, whether he be union, industry, government, or *a fellow colleague.*

Coleman C. Johnston, M.D., Lexington
William K. Massie, M.D., Lexington

**See footnote on opposite page.*



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WASHINGTON NEWS DIGEST



WASHINGTON, D. C. — The U.S. Chamber of Commerce and two key Congressmen, all opponents of the so-called Forand bill, recently issued separate warnings that an all-out effort will be made to get the controversial legislation through Congress next year.

In its weekly report to members, the Chamber predicted there will be "a powerful attempt" in the next session of Congress to enact the bill (H. R. 4700) which would increase social security taxes to help pay for the cost of the Federal government providing surgical and hospital care for social security beneficiaries.

The Chamber warned that passage of the legislation would mark "a major break-through into the welfare state." It "probably would lead to a compulsory Federal program providing complete medical care for everyone," the Chamber said.

The Chamber called upon communities to find orderly solutions to the problems of the aging. Otherwise, solutions "will surely be imposed from Washington," the report added.

* * *

Similar warnings were voiced by Reps. Richard M. Simpson (R., Pa.) and Thomas B. Curtis (R., Mo.), key members of the House Ways and Means Committee where the bill was put on the shelf last session.

Republican Curtis urged that the medical profession and other leading opponents make a strong counter-drive in an all-out effort to block passage of the bill next session. Unless there is such action, he said he would have to "regretfully" predict that legislation along the lines of the pending bill probably will be enacted in 1960.

Republican Simpson said that H. R. 4700, and similar legislation affecting the medical profession, "make it imperative that every doctor keep informed on legislative issues before Congress." He also urged that physicians "become patriotic political forces" by giving "their informed viewpoint" to lawmakers at all levels of government.

Republican Simpson said it "is important" that opponents of H. R. 4700 develop "appropriate alternatives" to solve the health care needs of the aged.

He promised to continue to cooperate with the medical profession to guard "against the disastrous consequences of compulsory national health insurance."

* * *

House Democratic Leader John McCormack of Massachusetts expressed hope that Congress next year will stamp final approval on another bill of particular interest to physicians. He praised the Keogh-Simpson bill (H. R. 10) as "meritorious legislation" and said it "should be enacted into law next year." The measure, which was passed by the House last spring but left hanging in the Senate Finance Committee, would provide income tax deferrals for self-employed persons setting aside money for private retirement plans.

A National Republican Committee on "Program and Progress" proposed a far-reaching health program to be carried out by the Federal government in partnership with states and local governments.

Its goals would include: enlarging the capacity of medical schools so that 3,000 more doctors could be graduated each year, providing more hospital and nursing home beds, and supplementing hospital facilities with clinics, day-care centers and more visiting nurses to care for patients in their own homes.

The progress of medical science would be furthered by continued Federal support for basic medical research. But such Federal support would be given under conditions to encourage maximum non-Federal spending on medical research and to prevent "too great a diversion . . . of doctors required for the equally urgent needs of teaching and medical practice." It was estimated that expenditure of $1 billion a year—equally divided between the Federal government and non-Federal sources—would be required by 1965.

Other recommendations included: vigorous Federal support of preventive health programs, and expansion and greater flexibility of voluntary health insurance programs.

* * *

"A free people and a free medical profession can achieve these goals with the wise support of government, without bureaucratic restrictions or interference with the physician-patient relationship which has made American health services a model for the free world," the Republican Committee stated.

The Committee prosposed a five-point "partnership" program:

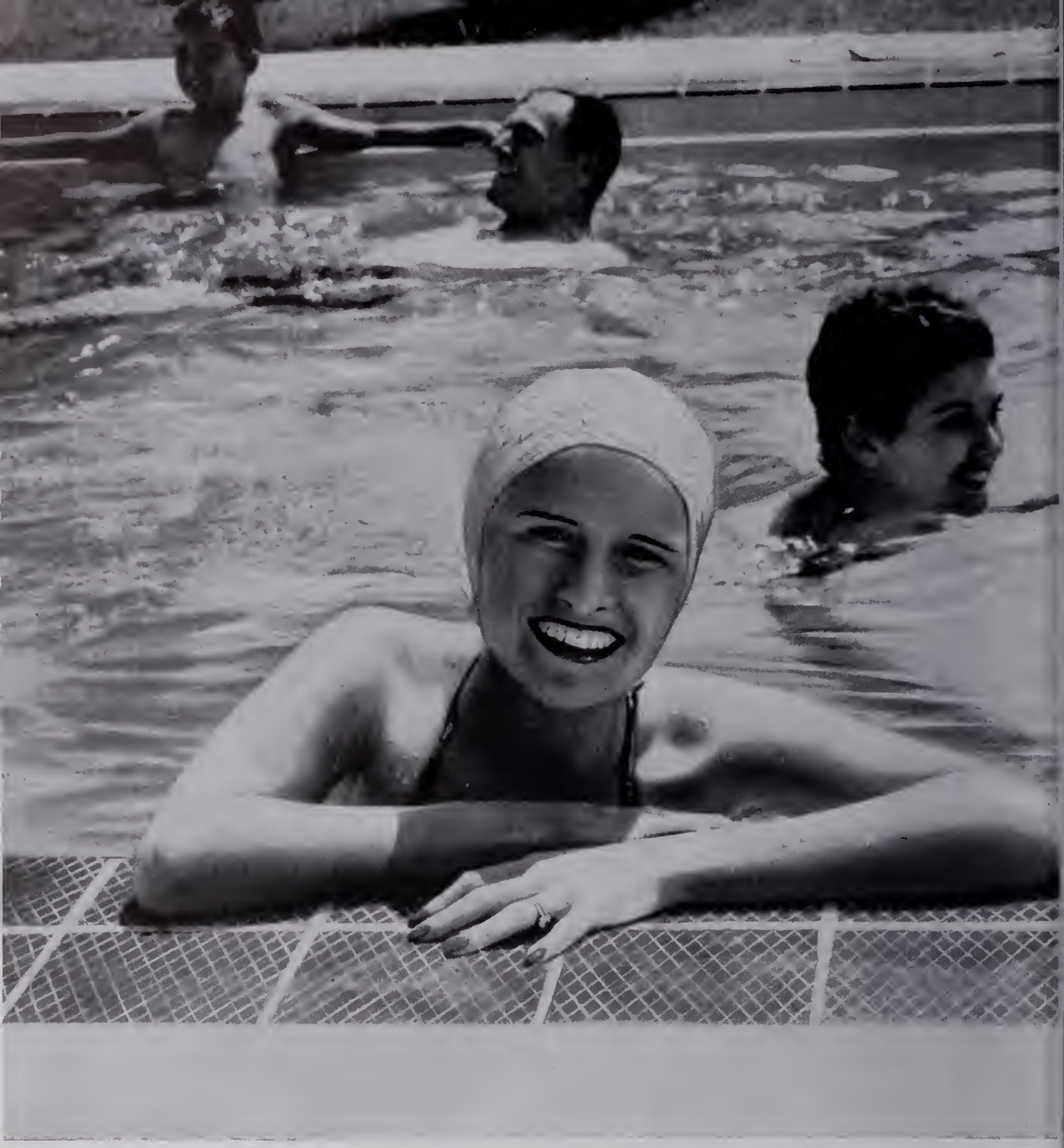
1) short-term Federal aid for construction of medical school buildings.

2) changes in the present hospital construction program to encourage renovation and repair of outmoded hospitals.

3) Federal guarantees for mortgages to finance construction of private nursing homes on a basis assuring high standards of quality in construction and operation.

4) encouragement of construction of diagnostic and outpatient facilities in rural areas and the building of mental health clinics.

5) Federal aid to cities "in more effective planning and coordination of health services."



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When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

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POVAN SUSPENSION is administered orally in a single dose. In small children, the dose is equivalent to 5 mg. pyrvinium base per Kg. of body weight.

For convenience, a 5-cc. teaspoonful per 22 pounds (10 Kg.) of body weight may be recommended. For example, a 54-pound child would receive somewhat less than 3 teaspoonfuls of the Suspension.

Adults also may be given POVAN SUSPENSION according to the same dosage schedule.

Note: Parents and patients should be informed that POVAN SUSPENSION will color the stools a bright red and that, if spilled, will stain.

Supplied: POVAN SUSPENSION is available as a pleasant-tasting, strawberry-flavored suspension containing the equivalent of 10 mg. pyrvinium base per cc., in 2-oz. bottles.

(1) Beck, J. W.; Saavedra, D.; Antell, G. J., & Tejeiro, B.: **Am. J. Trop. Med. 8**:349, 1959.

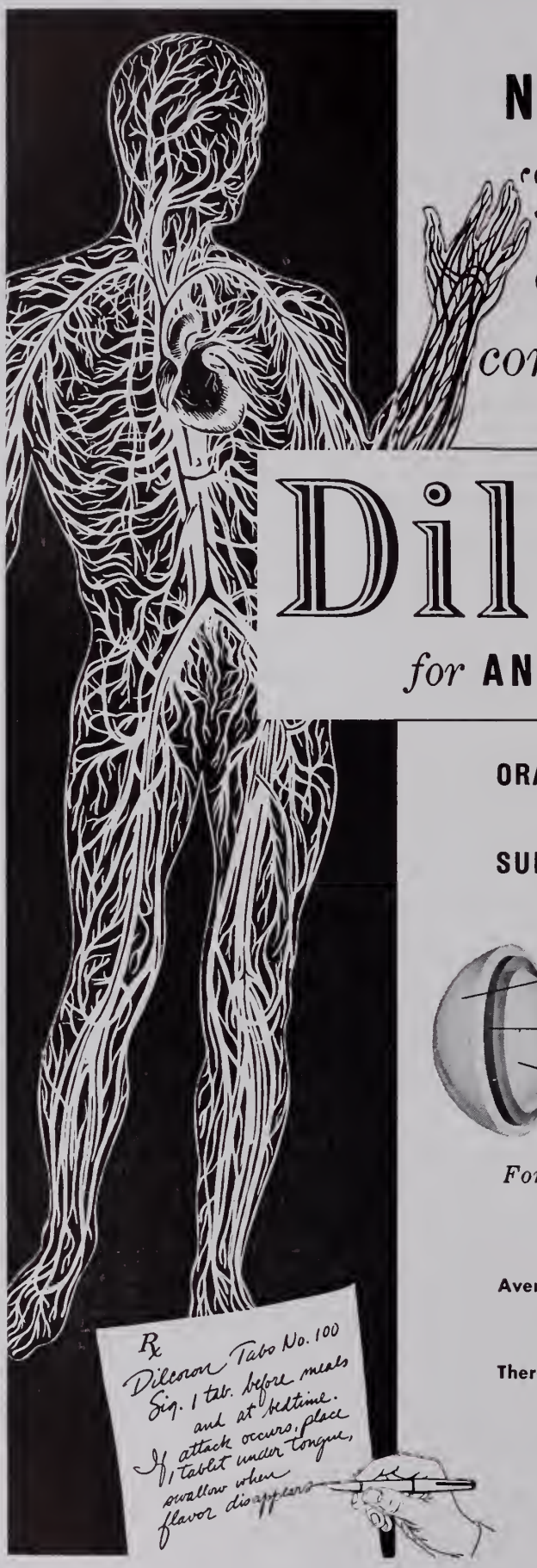
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SUBLINGUAL-ORAL
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Citrus "flavor-timer"
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Pentaerythritol tetranitrate
—15 mg. (1/4 grain)—prolongs action

For continuing prophylaxis patient swallows the entire Dilcoron tablet on an empty stomach.

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Average prophylactic dose:
1 tablet four times daily
(½ hour before meals and at bedtime).

Therapeutic dose:
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for the acute asthmatic attack

rapid control by the oral route
without fear of g.i. intolerance

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the *buffered* theophylline that permits adequate oral xanthine dosage...better absorbed and better tolerated than aminophylline...formulated to provide effective blood levels in just 15 minutes

Each tablespoonful (15 ml.) contains 0.33 Gm. (5 gr.) theophylline sodium glycinate, equiv. 0.16 Gm. (2½ gr.) Theophylline U.S.P.; 20% alcohol.

Dosage: Adults—2 tablespoonfuls t.i.d. Children—2 to 3 teaspoonfuls if over 12 years; 1 to 2 teaspoonfuls if 6-12 years; 1 teaspoonful if 3-6 years; ½ to 1 teaspoonful if 1-3 years. May be repeated after 8 hours.

Bottles of 1 pint, 1 gallon.

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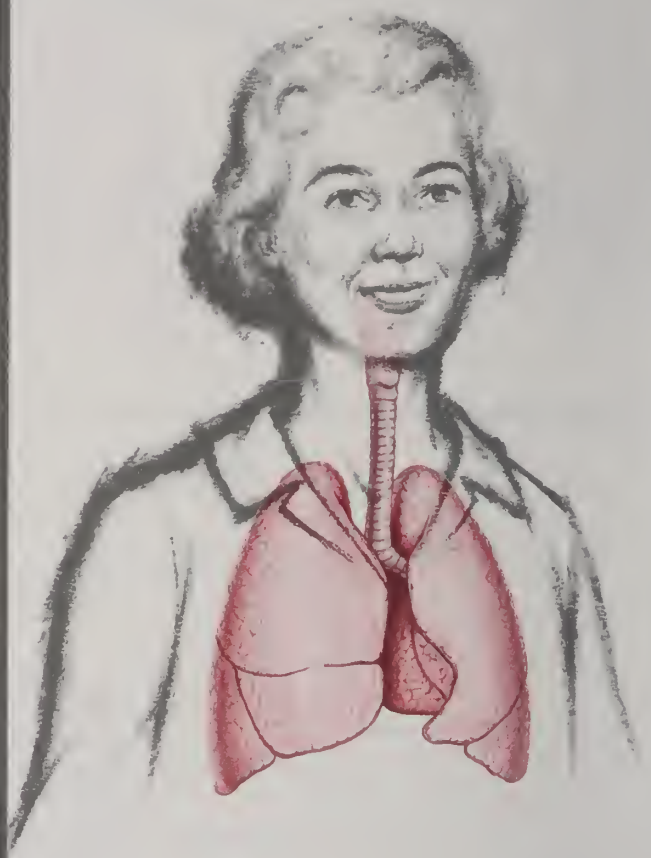
...and for routine management **SYNATE TABLETS**

for subacute
and chronic
asthma
...pulmonary
emphysema
and bronchiectasis

comprehensive
symptomatic control
by the oral route
without fear of
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the optimally effective, well-tolerated oral xanthine[1-3]—theophylline sodium glycinate—in a comprehensive formulation for full symptomatic control...keeps patient comfortable and reduces incidence and severity of acute attacks • in emphysema due to allergic asthma or chronic infectious bronchitis, it provides rapid bronchial dilatation, as well as decongestant and expectorant benefits

Each SYNATE Tablet contains:

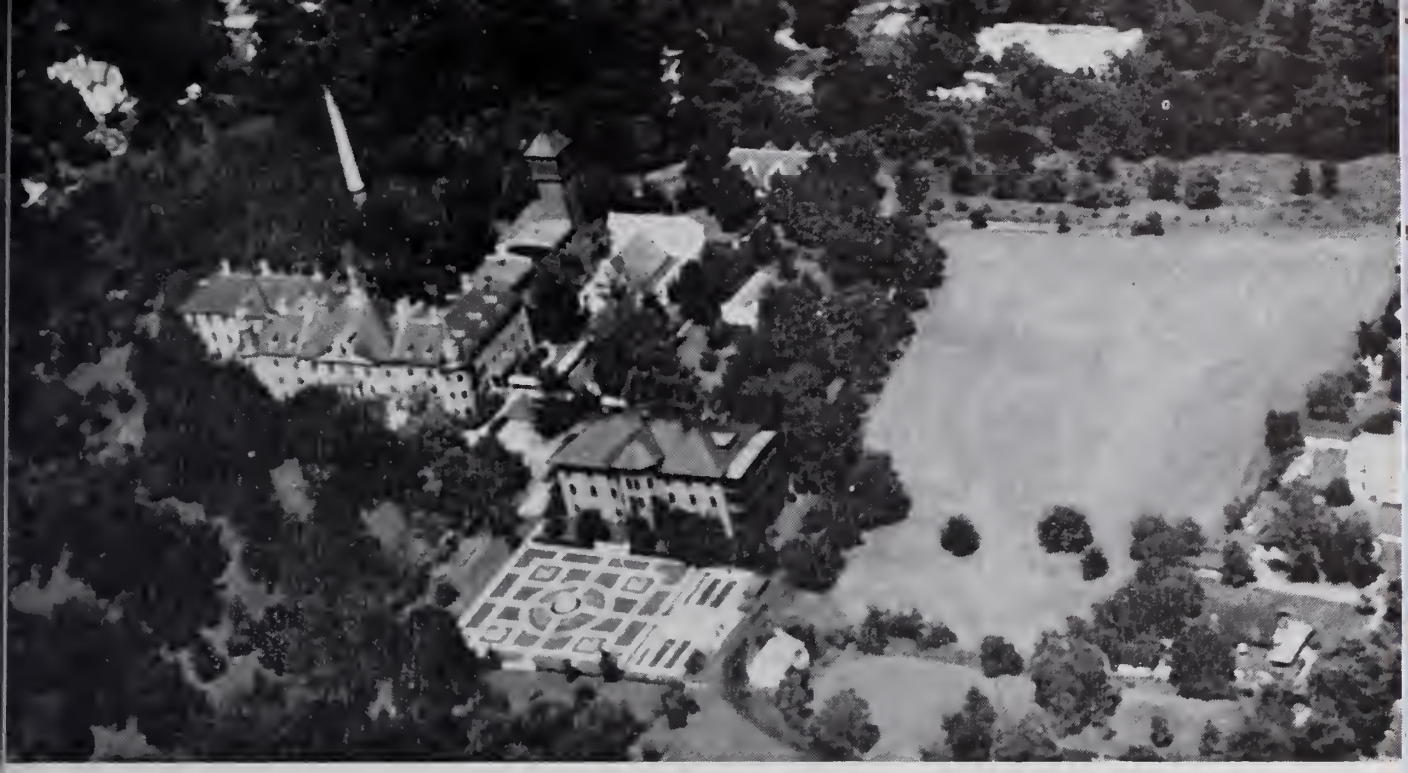
Theophylline Sodium Glycinate (SYNOPHYLATE®)	360 mg.
Racephedrine Hydrochloride	30 mg.
Potassium Iodide	300 mg.
Secobarbital (Warning: May be habit-forming)	20 mg.
Niacinamide	40 mg.

Dosage: One tablet q.i.d. with water.
Bottles of 100, 500.

1. United States Dispensatory (Osol-Farrar), ed. 25, Philadelphia, Lippincott, 1955, p. 1412. 2. A.M.A. Council on Drugs: New and Nonofficial Drugs 1959, Philadelphia, Lippincott, 1959, p. 389. 3. Grollman, A.: Pharmacology and Therapeutics, ed. 3, Philadelphia, Lea & Febiger, 1958, p. 208.

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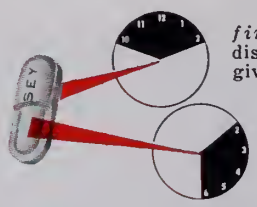
TRIAMINIC® .....50 mg.
(phenylpropanolamine HCl .....25 mg.
pheniramine maleate .....12.5 mg.
pyrilamine maleate .....12.5 mg.)
Dormethan
(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate .....180 mg.
APAP (N-acetyl-p-aminophenol) .....325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

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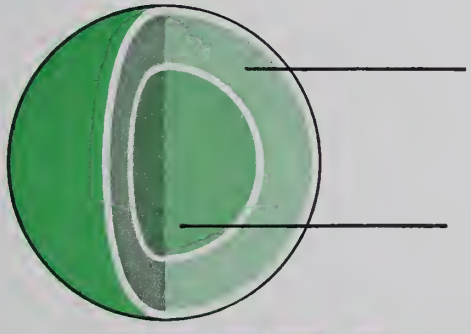
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the complaint: "nervous indigestion"

the diagnosis: any one of several nonspecific gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy. **the prescription:** a new formulation, incorporating in a single tablet the actions of Donnatal and Entozyme. **the dosage:** two tablets three times a day, or as indicated.



the formula: *in the gastric-soluble outer layer:*

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N.F.	150 mg.

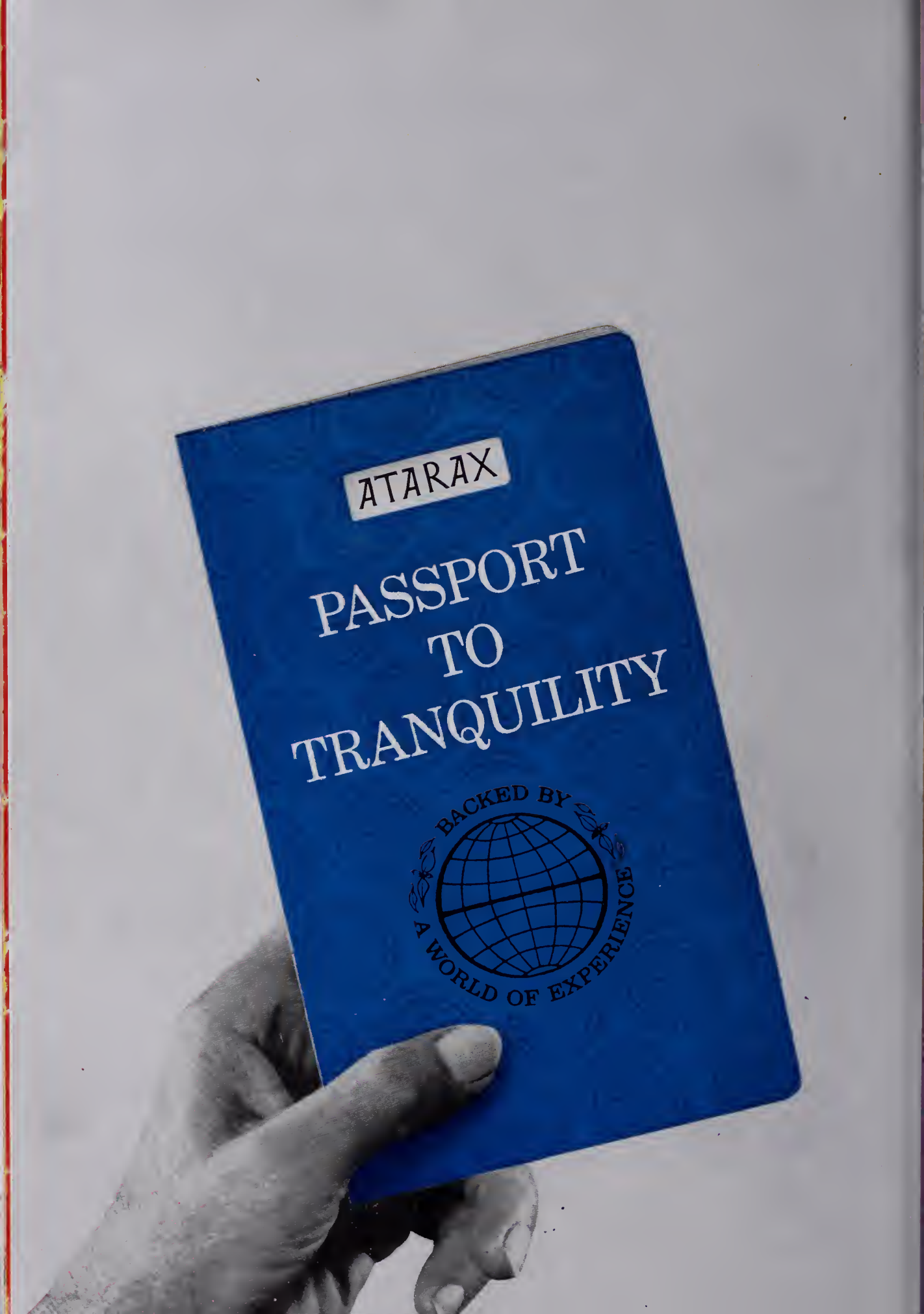
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Pancreatin, N.F.	300 mg.
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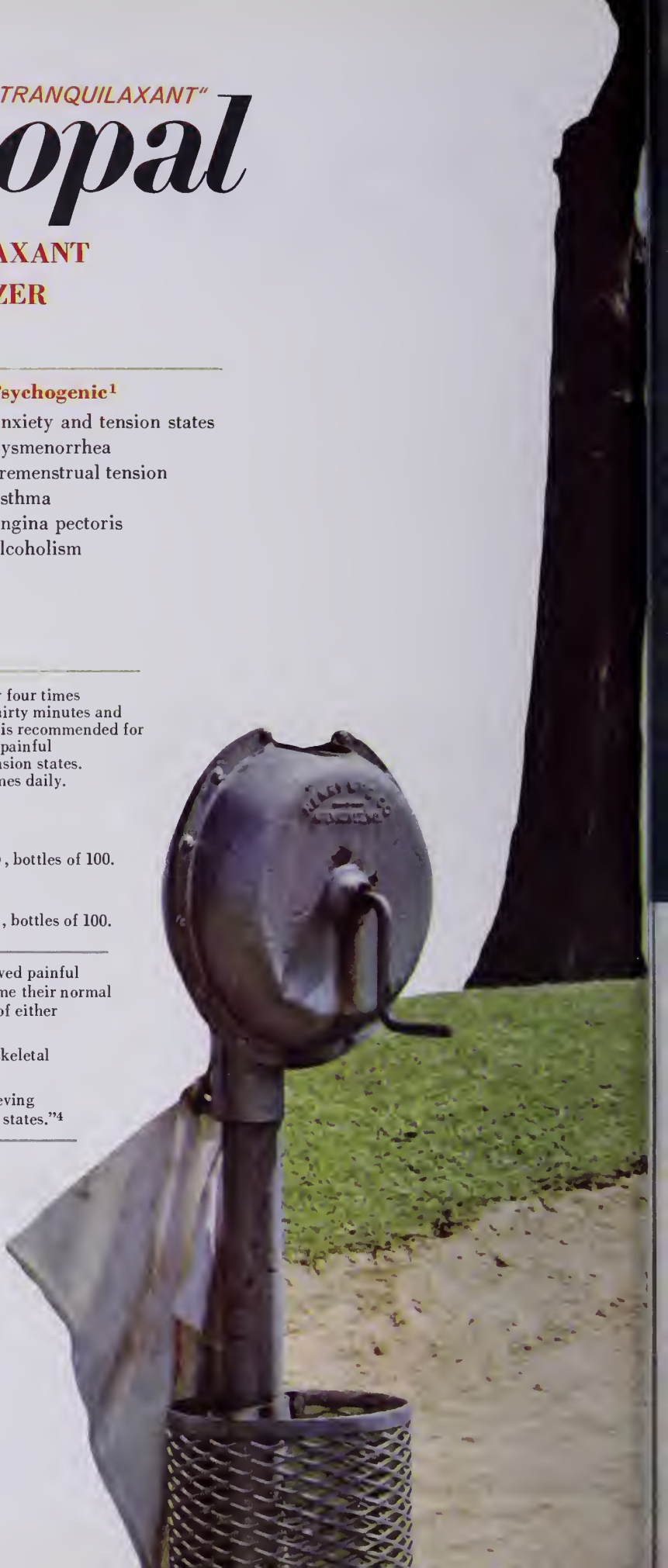
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Symposium on Carcinoma Of The Lung

Etiology, Symptomatology And Diagnosis Of Carcinoma Of The Lung

OSCAR O. MILLER, M.D.

Louisville, Ky.

THIS discussion of carcinoma of the lung is concerned primarily with endobronchial carcinoma, the so-called squamous cell carcinoma, and the undifferentiated (oat cell) carcinoma.

Incidence

It is an established fact that the incidence of carcinoma of the lung has increased remarkably over the past fifty years. It is unlikely that this increase is due entirely to better diagnosis, since the same phenomenon has been observed consistently in autopsy material. In 1914 the incidence of carcinoma of the lung was almost identical in white males and females; the incidence was still quite similar in both sexes during the period from 1930 to 1932. During the period from 1939 to 1941 the incidence of carcinoma of the lung in white males was almost double that in white females; in 1949 and 1950 the rate in males almost quadrupled that in females.[1] It is interesting that, during this same period, the incidence of carcinoma of the lip, larynx, pharynx and esophagus also increased at a greater rate in males than in females.[2] The incidence of carcinoma of the lung in males rises sharply at age 55, reaches a peak between the ages of 60 and 75, and then declines rather sharply to the age of 90. In contrast, the incidence in females rises gradually throughout life, reaching a peak at approximately the age of 80.

Etiology

The statistical studies on the etiology of endobronchial carcinoma are controversial. During the past twenty years there has been a growing conviction in some quarters that cigarette smoking may in some way be responsible for the markedly increased incidence of carcinoma of the lung. Wynder and Graham[3] have investigated this problem intensively. Their conclusions were based on a study of 684 proved cases of bronchogenic carcinoma. They reported that 96.5 per cent of men suffering

The Journal of the KSMA presents its second annual scientific symposium, with Wallace E. Herrell, M.D., Lexington Clinic, Lexington, as Special Symposium Editor. The series was authorized by the Editor and his Advisory Committee as a special service to readers.

with bronchogenic carcinoma were either moderately heavy or "chain" smokers. The incidence was highest in those who had smoked for thirty to forty-nine years. Ninety-six per cent had smoked for over twenty years. These investigators concluded that the excessive and prolonged use of cigarettes and inhaling of smoke seemed to be an important factor in the development of bronchogenic carcinoma. It is generally conceded that the incidence of carcinoma of the lung in pipe and cigar smokers is no greater than that in non-smokers, the inference being that most cigarette smokers inhale, while most other smokers do not.

In a study of 1,045 males who had carcinoma, Levin and his collegues[4] did not confine their observations to endobronchial carcinoma, but included carcinoma involving numerous other sites. It was their conclusion that in a hospital population cancer of the lung occurs more than twice as frequently among those who have smoked cigarettes for twenty-five years than among other smokers or non-smokers of comparable age. They call attention to the greater incidence of cancer of the lip among pipe smokers. They suggest a casual relationship between cigarette smoking and lung cancer, but do not consider it an established fact.

Extensive Study

An extensive study was undertaken by Hammond and Horn[5] on 187,766 males between the ages of 50 and 69. These investigators were convinced that there was a definite association between smoking and the death rates for carcinoma of the lung, as well as coronary heart disease. They report a 456 per cent increase in consumption of cigarettes during the period from 1920 to 1953. During the period from 1930 to 1948 the standardized death rate for white males in the United States for most diseases declined, while that for lung carcinoma and coronary heart disease markedly increased. For example, in 1930 the death rate for carcinoma of the lung was 5.3 per 100,000, while in 1948 it was 27.1 per 100,000, an increase of 411 per cent. During this same period the death rate from coronary heart disease also rose 286 per cent.

Doll and Hill[6] reported data on smoking habits accumulated from questionnaires circulated to 40,000 British physicians. This study revealed that the death rate of heavy smokers was twenty times that of non-smokers. The highest mortality rate occurred in the cigarette smokers.

An increase in the incidence of carcinoma of the lung also has been reported in females. There is a higher incidence of adenocarcinoma in women than in men. Wynder and his colleagues[7] reported on a series of 196 cases of carcinoma of the lung in women. In this series 42 per cent were adenocarcinomas, 32 per cent epidermoid carcinomas, 18 per cent anaplastic carcinomas, and 8 per cent unclassified. Epidermoid carcinoma of the lung in women was found to occur at an earlier age in women who smoked than in those who did not. Also, there was a higher incidence of previous lung complaints and chronic cough in women suffering with epidermoid carcinoma than in those who had adenocarcinoma. The smoking habits of women with adenocarcinoma were similar to those of a large sample of women in the general population, whereas in the group with epidermoid carcinoma of the lung there was a greater percentage of heavier smokers. Most investigators agree that smoking has little, if any, influence on the development of adenocarcinoma in women but that heavy smoking is statistically significant in the group with epidermoid and undifferentiated carcinoma of the lung.[5-8] It is quite possible that the difference in the incidence of lung cancer in men and women is unrelated to sex and is more likely due to the fact that women smoke considerably less than men and have smoked over a much shorter period of time.

The death rate due to cancer of the lung in England and Wales in 1955 was 2.1 times as high as that in the United States, despite the fact that the per capita consumption of cigarettes in the former countries is much lower than that in the United States. This difference may be due to the habit in Britain of smoking considerably more of each cigarette. The average cigarette butt measured 18.7 mm. in Britain, as compared to 30.9 mm. in the United States. Wynder has reported that the last half of the cigarette contains 60 per cent of its tar. Taking cognizance of this fact, the Swedish tobacco monopoly printed two thin

rings on their king size cigarettes and advised that they not be smoked beyond this point. Despite this, smokers continued to smoke the cigarettes to the usual stub, misinterpreting the tobacco industry's solicitude as a scheme to increase sale of their product.

117 Patients Studied

Those who refuse to accept the statistical evidence of a relationship between carcinoma of the lung and smoking argue that evidence should be produced to show precancerous changes in the endobronchial mucosa resulting from the inhalation of tobacco smoke. Auerbach and his colleagues[9] undertook a series of studies in support of the hypothesis that inhalation of air pollutants and cigarette smoke is capable of setting up changes in the endobronchial mucosa. They studied the endobronchial mucosa of 117 patients who had died. All of the patients were white males, whose ages ranged from 22 to 88 years. Two-thirds were between the ages of 50 and 70. The bronchial tree was dissected from the lungs and divided into 208 sections. In all, 80,000 microscopic examinations were made. Only patients with adequate smoking histories were included in the study. Thirty-four bronchogenic carcinomas were found, and the average age of these patients was 58. There were 83 patients who died from various causes other than carcinoma of the lung. Of those who never had smoked regularly, 18.6 per cent were found to have basal cell hyperplasia, whereas 36.1 per cent of those who had smoked over a package of cigarettes per day were found to have the same histologic changes. The incidence of squamous cell metaplasia seemed to parallel the amount of smoking. The incidence of carcinoma in situ in heavy smokers was 8.5 per cent, compared with an incidence of 1.9 per cent in those who had never smoked regularly.

Air Pollution

The matter of air pollution deserves comment. Most statistical studies show a higher incidence of cancer of the lung in urban than in rural areas. This suggests the possibility of the presence of carcinogens in the atmosphere. Stocks [10] examined the standardized mortality ratios as related to the average amount of undissolved deposit and smoke from the air in fifty-eight towns in industrial areas in England. Significant correlations were found with both types of pollution. Bronchitis was correlated with atmospheric deposit but not with smoke, whereas lung cancer was correlated with smoke but not with deposit. This provides no explanation, however, for the marked difference in the mortality rate of cancer of the lung in men and women living in the same areas. Hammond and Horn[5] reported a higher rate of carcinoma of the lung in highly urban areas than in highly rural areas. However, their investigation showed further that the incidence of heavy cigarette smoking was greater in the urban population. Mills and Porter[11] reported that the death rates in both coronary heart disease and endobronchial carcinoma were definitely higher in the polluted urban areas than in the cleaner suburban areas. They also reported a higher incidence of both diseases in those individuals who drive in excess of 12,000 miles per year, although the exacerbating relationship was much greater between smoking and lung cancer than for cardiovascular disease.

Theory Challenged

Berkson,[12] a biometrician, challenges the theory that cigarette smoking specifically causes endobronchial carcinoma, because the evidence is derived from statistical studies that he calls "prospective" and is not supported by experimental evidence, since no endobronchial carcinomas have been produced in animals by having them inhale cigarette smoke. He concedes from the statistical studies (Doll and Hill[6] and Hammond and Horn[5]) that cigarette smokers show an excess death rate over nonsmokers in a number of categories, such as coronary artery disease, 52.1 per cent; other heart and circulatory conditions, 5.8 per cent; pulmonary affections, 5.6 per cent; cerebrovascular disease, 4.8 per cent; lung cancer, 13.5 per cent; and other cancer, also 13.5 per cent. The implication is that, if cigarette smoking is a factor, endobronchial cancer should exceed, rather than equal, other cancers.

It is quite evident that there are carcinogens in polluted air, automobile exhausts, bonfires, certain industrial processes, mining, and cigar-

ette smoke. Not all smokers develop endobronchial cancer, but most individuals who develop this lesion have been moderately heavy to heavy cigarette smokers. The evidence is incontrovertible that there is a definite relationship between cigarette smoking and the evolution of endobronchial carcinoma.

The influence of the tobacco industry extends into many phases of American life, from the tillers of the soil to every legislative assembly in the nation. The production of cigarettes alone in 1956 exceeded 424 billion. The United States Treasury, during 1957 and 1958, received $1,734,021,000 in excise tax from tobacco.[13] It is understandable that the vested interests will employ every means available to protect this source of revenue. The tobacco industry has met the challenge. They have organized a Research Committee[14] and have appropriated $3,200,000 to subsidize research projects on this subject. At the present time seventy-five scientists and fifty institutions are participating in these projects in an effort to obtain an unbiased answer to this problem. It is obvious that the millions of people now smoking are not going to give up the delectable habit. The hope for the future may lie in the removal of carcinogens from tobacco.

Symptomatology

In general, symptoms are the primary motivating force that bring the patient to the physician's office. If symptoms do not prompt the patient's visit, it is often fear engendered by reading articles on medical subjects that causes him to seek medical attention. There are no pathognomonic signs or symptoms of carcinoma of the lung. In the evolution of cancer there is too frequently a long period of latency coupled with early metastasis to the blood stream.[15] This lethal combination may be one of the factors accounting for the small number of five-year survivals following surgical treatment, notwithstanding the fact that many of the cancer cells are destroyed in the blood.

Cough is the most prominent and constant symptom of carcinoma of the lung. Since morning cough is a concomitant of cigarette smoking, the patient is prone to ignore it. Often some member of the family will persuade the patient to present himself for examination. A wheeze, when present, is significant, but is usually not noticed by the patient until it has become rhonchial in character. The patient may state that he cannot take a deep breath and that "the air does not seem to go all the way down." Hemoptysis invariably impells the patient to seek advice. The spitting of streaked sputum or frank hemorrhage is an important symptom; the older the patient, the more significant. Weakness out of proportion to the clinical and roentgenologic findings is a suggestive, but late, symptom. Unequivocal pain, more or less constant and of varying degree, is one of the most compelling symptoms and warrants careful investigation. Dyspnea may be present in those cases in which an intractable pleural effusion has supervened.

Diagnosis

As is true of the symptomatology, there are no pathognomonic diagnostic criteria for carcinoma of the lung. All that wheezes is not asthma. A localized and persistent wheeze is important. The wheeze usually is more pronounced on forced expiration, during which the bronchi shorten, contract and rotate on their axes. In the patient who has been a heavy smoker, a generalized wheeze may be present, but it usually is more evident over the suspected area.

Metamorphosing breathing is most important. It begins as vesicular breathing and ends more or less as bronchial breathing, with a distinct burp at the end of full inspiration. Any narrowing of the bronchus from within or from without may produce it. Partial occlusion due to tenacious sputum also may produce it.

To many, percussion is "stale, flat and unprofitable," but to him who has patience and skill, it may prove rewarding. Naturally, any change in percussion note will depend on the character and extent of the lesion. Massive lesions produce a flat, wooden note. Inspection and palpation for limitation of excursion are not revealing and are only mentioned in passing. Pressure symptoms of tumors in the upper mediastinum may be only too obvious when they are well advanced. However, one should palpate for cervical, supraclavicular and axillary adenopathy.

One of the most vexing problems in the diagnosis of carcinoma of the lung is the presence of the spherical densities frequently observed in the lungs. The average surgeon considers that all such lesions should be explored and removed. He can cite statistics in support of this opinion and, on occasion, even when he is convinced that the density is a caseous tubercle, will tell the patient that it may rupture and spread throughout the lung or body. He is honest in his conviction but would be hard put to cite even a single example that this is the sequence of events of such caseous tubercles. Any competent phthisiologist has seen innumerable cases in which such caseous nodes, even with satellite tubercles, eventually completely absorbed and cleared, quite often with calcification. These things were observed long before antibiotics and chemotherapy were available and prior to the development of thoracic surgery. Such caseous tubercles are a manifestation of resistance and represent a reparative process. We are speaking here of productive tubercles that are sharply delimited with well-defined borders, in contrast to exudative foci with ill-defined, blurred margins which connote pathologic activity. In fact, productive tubercles carry within them certain basic compounds which possess antimicrobial activity capable of inhibiting multiplication of Mycobacterium tuberculosis.

A Sane Approach

O'Brien et al[16] approach the problem sanely, stating: "The argument for widespread resection is that the patient's future would be less hazardous if all lesions including nubbins were removed. However, a patient is better off with no surgery at all if he does not need it."

Unfortunately, the term "tuberculoma" has been introduced as a definition of such lesions observed on the photofluorographic and x-ray films. The term is misleading and should be reserved for solitary lesions in the brain or liver, where its evolution proceeds symmetrically, unhampered by planes of fascia or strands of connective tissue.[17]

Clinically, then, what is the proper approach to diagnosis and correct evaluation of these isolated densities in the lung? The reported percentage of malignancies varies from 4.5 to 49 per cent, according to the age of the patient on whom operation is performed. Higginson's and Hinshaw's[18] figure of 10.3 per cent may be more nearly accurate. In the majority of cases these spherical lesions are associated with no symptoms or physical signs, and usually are discovered by mass roentgenography or on routine chest fluoroscopy or x-ray incidental to a physical examination. To determine whether it is carcinoma, tuberculosis, histoplasmosis, coccidioidomycosis, hemartoma, et cetera, one must resort to appropriate skin testing and may elect body section radiography to determine if there is a central area of pinpoint calcification. If calcification is present, it is not malignant. I say this advisedly, knowing full well that malignancies have been removed which contained areas of calcification and that cancers not infrequently take their origin in the lung where calcification is present. It is here that experience and clinical judgment must be exercised to the patient's best interests. The size and character of the lesion and the age and sex of the patient all are determining factors as to whether resection or observation is indicated.

Fate of Spherical Densities

The fate of such spherical densities may be determined from five-year follow-up studies, such as that conducted by Holin et al.[19] From a mass chest x-ray study in Cleveland embracing 673,218 adults in 1949, they selected in 1954, 666 persons whom they considered had solitary nodules, for a follow-up study. All except twenty-two individuals were traced. The etiology of the densities was established in 13.8 per cent. Only 3 per cent of the nodules were proved to be malignant and 9 per cent tuberculous. No nodules with demonstrable calcification were found to be malignant. They state: "The risk of malignancy among an unselected group of solitary pulmonary nodules does not seem clear enough to warrant routine excision."

Fluoroscopic examination, in the hands of a competent fluoroscopist, is an invaluable approach to the diagnosis of intrathoracic lesions. While routine roentgenographic examination of the chest usually comprises stereoscopic and

lateral x-rays, they may at times fail to demonstrate certain lesions in the lung. Fluoroscopy permits the examiner to scrutinize the thoracic cage and its contents in the A.P. and P.A. positions, right and left anterior and posterior obliques, right and left lateral, and lordotic projections. The examiner has an opportunity to note the size, contour and position of the cardiac sillhouette and may study the roots of the lung, noting whether they are exaggerated, movable or fixed, or displaced with the respiratory excursion. At the same time the examiner may examine the position of the diaphragms and the extent of their excursion and also may note the condition of the costophrenic angles. Rotating the patient rapidly from the right anterior oblique to the left anterior oblique position frequently brings into view the platelike atelectasis not observed in P.A. projections. This, followed by lordotic examination, slowly rotating the patient through the right and left oblique positions, will be helpful. A thick barium swallow also is helpful in examination of the esophagus and mediastinum. The information gained by these examinations is of great value, since it makes it possible for the examiner to order x-rays that are most likely to provide him with the maximum information. On occasion, when the left diaphragm is elevated or obscured, the position of the diaphragm may be clarified by the following procedure. The patient is asked to swallow a Seidlitz powder or any of the popular effervescent preparations. The resultant gas bubble in the stomach frequently clarifies the left base and diaphragm.

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Roentgenographic Evaluation Of Primary Carcinoma Of The Lung

KENNETH D. MCGINNIS, M.D.*

Lexington, Ky.

THE chest is the most accessible area for roentgenographic demonstration of gross pathologic anatomy. Yet it can at times offer the greatest challenge to detection and diagnosis. This is especially true of the primary neoplasm of the lung, in that early diagnosis of the clinically asymptomatic lesion is almost essential if the now disappointing cure rate is to be improved. Guiss[1] has stated, probably correctly, that when bronchogenic carcinoma has become clinically evident, the chance for cure usually has been lost.

Since the early pulmonary carcinoma is clinically occult and since there is no laboratory method for effectively screening the general population, early detection becomes the responsibility of those who interpret roentgenograms of the chest. Detection by photofluorogram has both its detractors[2,3] and its enthusiasts.[1] The discouraging factors include: (1) The difficulty in obtaining a qualified reader, so that the number of missed positives or overread negatives does not defeat the program; (2) the increased threshold of lesion size, even to the experienced reader, and individual inconsistency of the experienced reader;[4] (3) the lapse of time between a positive survey film and definitive care; and (4) the low yield of curable cases. At the present time there is considerable concern regarding gonadal radiation exposure. Since the amount of exposure from photofluorograms is in the order of ten times that received from the conventional x-ray of the chest,[5] it appears that use of the conventional chest x-ray every six months is the best method for detection of early lung neoplasm. It is strongly recommended that male cigarette smokers over the age of 45 should obtain a conventional chest film every six months. Since this is not feasible for surveying the general population, at the present time the photofluorographic survey, in spite of the fact that it is not the method of choice, may well be the best method for mass surveys.

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Diagnosis

It is rare that an evaluation of the x-ray can give evidence sufficiently strong that histologic examination is not required. The roentgen study can give at least as much, and often more, diagnostic information as can isolated gross pathologic examination of a resected lesion. The various types of pathologic lesions will be discussed separately.

The solitary nodule.—The solitary uncalcified nodule proves to be malignant in approximately 40 per cent of cases. Radiologists and chest physicians alike have been seeking a method to select the malignant lesion that should be removed. The laminogram is essential in the evaluation of the solitary nodule in order to demonstrate more effectively the presence of calcification. Although calcification occasionally has been demonstrated in malignant lesions,[6] its presence, tempered with a little judgment, can be the best indication that the lesion is benign. The concentric rings of calcification of the typical granuloma are a certain sign that the lesion is not malignant. The calcification within the malignant lesion is a relatively small area compared to the entire abnormal zone. Lesions that are largely calcified can be con-

sidered benign. It is a rather unusual situation in which removal of a significantly calcified lesion is safer than observation. Roentgenographic signs that increase the suspicion of malignancy are the appearance of the nodule with a previous negative chest film or increase in the size of a previously noted uncalcified nodule. Another such sign is a notch or umbilication at the margin of the nodule, as described by Rigler.[7]

The solitary nodule, whether neoplastic or infectious, cavitates when there is both tissue necrosis and bronchial communication. The neoplastic cavity tends to have a thicker wall with a more irregular internal margin than that of a tuberculous cavity. However, the major differential point is the fact that the communicating infectious cavity almost always produces a strongly positive sputum.

Figure 1 demonstrates the clinical and x-ray problem of the so-called "coin" lesion. Its detection can be difficult at times. This lesion easily could be mistaken for an insignificant bone density in the overlying rib on the plain film (figure 1-A). The laminogram (figure 1-B) revealed this to be an uncalcified solitary nodule in an area where the diagnosis of old tuberculosis would be a tempting speculation.



Figure 1-A
Plain film showing poorly defined nodule superimposed upon rib density.

Figure 1-B
Clear laminographic demonstration.

This nodule was removed and proved to be an epidermoid carcinoma. Basically then, if laminography shows no calcification, the presence of a nodule of recent or unknown duration is an indication for immediate removal.

The early endobronchial lesion.—The early endobronchial lesion is a prime example of the advantage of a complete roentgenographic evaluation, including fluoroscopy, for suspected neoplasm. This lesion can be roentgenographically occult, with neither mass nor atelectasis

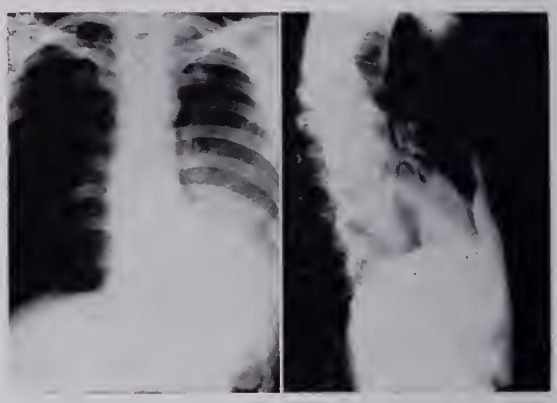


Figure 2
P. A. and lateral films show result of partial obstruction of the left lower lobe bronchus before collapse.

demonstrable. It can be demonstrated only in the patient who, because of a cough or a small amount of hemoptysis, becomes a neoplasm suspect and is referred for a complete chest evaluation. The earliest manifestation, which can be satisfactorily demonstrated only by fluoroscopy, is a differential aeration of a segment or lobe with mediastinal shift, always to the side of the lesion, on inspiration. This has a roentgenographic appearance quite similar to that which occurs with endobronchial foreign body in infants. The static position of the mediastinum may be central, ipsilateral or contralateral, depending on the degree of obstruction, without affecting the shift toward the lesion on inspiration.

The endobronchial lesion with obstruction.—Diagnosis of the endobronchial lesion producing obstruction is dependent on a close correlation of clinical and radiographic facts. Obstructive pneumonitis associated with a malignant lesion without significant collapse is always identical to infectious segmental or lobar pneumonia. Lobar infiltration due to simple infection is of rapid septic onset, while that due to obstructive pneumonia is of an insidious nature. Slow clinical improvement or slow roentgenographic clearing is an indication for

early bronchoscopy. By noting the area of lung involved, the radiologist can usually determine the location of the endobronchial abnormality. This is demonstrated in figure 2. This film shows increase in density, or drowning of the entire left lower lobe. This would indicate that the lesion, if present, must be accessible to the bronchoscopist. This lesion proved on bronchoscopy to be a bronchogenic carcinoma arising in the left lower lobe bronchus.

The next stage of progression of the endobronchial lesion is segmental or lobar atelectasis. Robins and Hale,[8] in a series of papers, describe the appearance of lobar and segmental collapse of the lung. This appearance of an atelectatic portion of the lung must be extremely well known to those interpreting roentgenograms of the chest. In the absence of compelling clinical information, segmental atelectasis always must be considered neoplasm until proved other wise. It should be remembered that on casual inspection collapse, at times, can be so complete as to give an almost normal appearance. This is due to flattening of the totally airless lung against or behind other structures of soft tissue density and the compensatory emphysema of the remaining uninvolved segments. This is an area where the higher kilovoltage chest x-ray films (125 to 150 KV) are of major advantage. In the high KV films the bronchi proximally can be well-demonstrated, with their distortion clearly shown, as well as penetrating the cardiac silhouette to demonstrate the lower lobe collapse and infiltration. Figure 3-A represents early collapse of the right upper lobe, the major finding being that of obstructive pneumonitis. Figure 3-B demonstrates almost complete collapse of the right lower lobe, where distortion of the major fissure and hilar depression are the principal features. This demonstrates the fact that early obstructive pneumonitis with a minor degree of collapse is much more readily apparent than is almost complete lobar or segmental collapse.

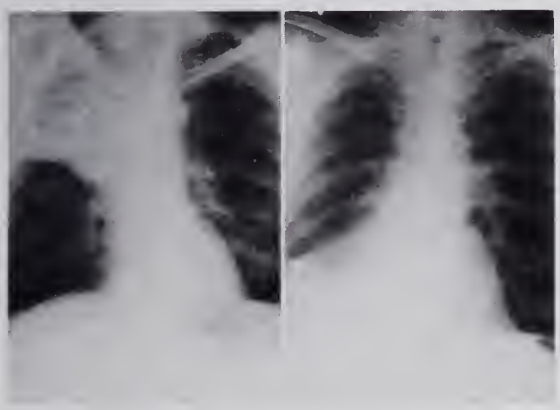


Figure 3-A
Obstructive pneumonitis with minor collapse of right upper lobe.

Figure 3-B
Major collapse of the right lower lobe. This shows that that the almost complete collapse of the latter lesion is the more difficult to demonstrate.

The hilar mass.—The early lesion arising within either lung hilum is a difficult diagnostic problem. This often is due to the fact that the tumor cannot be isolated from normal hilar shadows in any projection. It is simply within the hilar complex, which in any patient contains many lymph nodes of normal size as well as the pulmonary vascular densities. The detection of early enlargement of one of these nodes or the early mass lesion from the small perihilar bronchi is of great diagnostic significance. It was first thought that the criteria suggested by Rigler[9] and his colleagues for hilar measurements would be diagnostic, but later studies[10] and personal experience have shown these to be of only occasional value. Figures 4-A and 4-B show two hilar neoplasms with normal hilar measurements. The laminogram, as well as fluoroscopy and observation in the ideal projection, is of help in these cases, but individual interpretation of the routine PA film

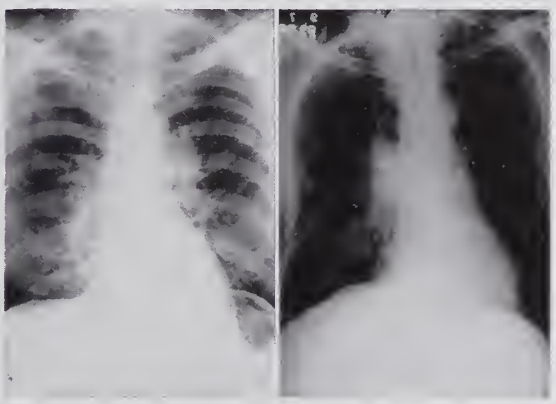


Figure 4-A
Left hilar sarcoma.
Figure 4-B
Right hilar carcinoma. These hila are within the range of normal in measurement.

remains the most accurate means of detection of the early lesion. These lesions usually are inaccessible to the bronchoscope. Therefore, confirmation of the diagnosis is obtained only by exfoliative cytology prior to exploration.

An entirely different problem is that offered by an obvious hilar or mediastinal mass which may or many not be neoplastic. Figure 5 demonstrates such a case. The plain chest film revealed the presence of a tumor density adjacent to the left hilum. A neoplasm was, therefore, suspected. The laminogram failed to show that the mass had a discrete margin, and the proximal bronchi were well demonstrated and normal. In this particular case surgical exploration confirmed the opinion obtained by use of the laminogram that this lesion was inflammatory. In such a case it is reasonable to follow the process at intervals of about a week until clearing occurs.

Special studies, such as vascular contrast studies, are on occasion of value in the diagnosis of the hilar mass. Figure 5 represents such a case. The symptomatology and clinical findings in this case led to a tentative diagnosis of a neoplastic process. There was a mediastinal mass (figure 6-A), which could not be separated from the vascular structures; there was no evidence of cardiovascular abnormality, and no cardiac murmur could be heard. A selective angiocardiogram was performed (figure 6-B), which revealed this to be the "idiopathic" dilatation of the pulmonary artery. This patient was, therefore, spared a needless exploratory thoracotomy.

Multiple peripheral densities.—Bronchiolar-cell carcinoma most often appear as multiple poorly-defined densities in one or both lungs. Whether this represents multicentric origin, as suggested by Liebow,[11] or early spread of the lesion,[12] has not yet been determined with certainty. Since these lesions arise peripherally from the bronchioles, the obstructive changes commonly seen in bronchogenic carcinoma rarely are present. It is usually impossible to differentiate this lesion from multiple metastatic lesions, since both may be either infiltrating with ill-defined densities or locally expanding to produce the sharply demarcated peripheral nodule. However, the bronchiolar-cell carcinoma is most commonly an infiltrating tumor, while metastatic lesions usually are fairly discrete.

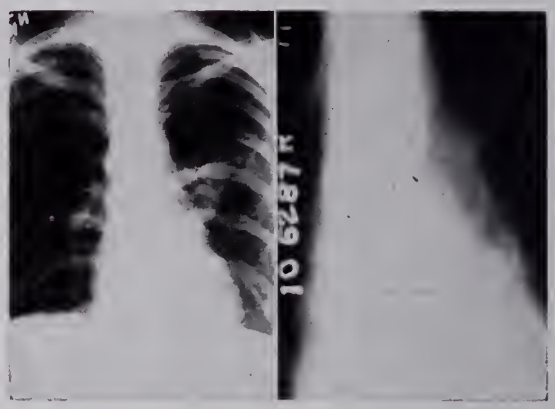


Figure 5-A
"Tumor" density of left hilum.
Figure 5-B
Laminogram showing loss of definition of pseudo-mass and normal proximal bronchi.

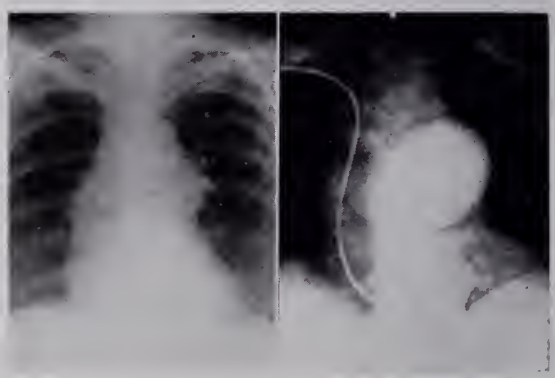


Figure 6-A
Mediastinal mass density.
Figure 6-B
Selective angiocardiogram demonstrates this to be a dilated, undivided pulmonary artery segment.

Discussion

Little has been said about the differential diagnosis of each gross pathologic type. The major role of roentgenology is the detection of the lesion and the indication of the process most likely to lead to the diagnosis. When a solitary nodule is present in the periphery, it is wasted effort to suggest bronchoscopy. The laminogram will be of great value in the demonstration of the presence or absence of calcium, which is very important. If the lesion is uncalcified, it is useless to speculate as to the exact diagnosis. Uncalcified nodules include carcinoma, primary or metastatic; tuberculoma; organized hematoma. The exact nature of the lesion can be determined only on histologic examination. On the other hand, it has been

clearly shown that the conventional x-ray of the chest can demonstrate the position of a lesion and whether it is within reach of the histoplasmoma; hamartoma; or intrapulmonary bronchoscope. It also is helpful in locating the lesion by using the laminogram. If the lesion cannot be demonstrated by either of these latter two methods, one should be most hesitant to advise surgical exploration.

The question is often raised as to the roentgenographic determination of the operability of carcinoma of the lung. The presence of distant bony metastasis or peripheral involvement of both lungs indicates that the lesion is inoperable. There are no other satisfactory criteria to the operability of such a lesion. In general, it can be stated that the prognosis is better when the carcinoma is located in the periphery, rather than centrally. The very important biologic predetermination of the individual tumor remains unpredictable by means of x-ray.

Diagnostic Procedures

Specialized and rather complex radiographic methods are at times of value in the diagnosis of carcinoma of the lung. However, fluoroscopy, plain film roentgenography and laminography are the most useful diagnostic procedures. Bronchography may at times be used to demonstrate a subsegmental endobronchial abnormality that is inaccessible to the bronchoscope and that has the appearance only of pneumonia on plain film. In fact, this is the major use of bronchography in the diagnosis of lung tumor. Selective or peripheral venography of either the superior or inferior venous circulation can occasionally demonstrate vena caval invasion before their syndromes can be diagnosed clinically.

It has been shown how the angiocardiogram may be useful when it cannot be determined conclusively by other methods if the mass is vascular, mediastinal or pulmonary. The aortogram usually can distinguish between the sacular aortic aneurysm and the neoplasm adjacent to or involving the aorta. Steinberg and Finby[13] state that involvement of the great vessels demonstrated by angiocardiography is an indication of nonresectability. If this becomes generally accepted, although at present it is not, this will greatly expand the indications for such studies.

Summary

1. The chest roentgenogram is the best present method for detection of pulmonary carcinoma.

2. Roentgenographic diagnosis is based on gross pathologic type.

3. The solitary pulmonary nodule without significant calcification at laminography should be evaluated histologically.

4. The earliest detectable endobronchial lesion produces no film change and must be discovered by observing a differential aeration of a pulmonary lobe or segment at fluoroscopy.

5. The endobronchial lesion progresses to produce obstructive pneumonia and then atelectasis.

6. While obstructive pneumonia is very similar roentgenographically, if not identical, to infectious pneumonia, major atelectasis almost always indicates an endobronchial lesion and this lesion, in the adult, is usually carcinoma.

7. Fluoroscopy, the plain roentgenogram and the laminogram are the major tools in diagnosis of pulmonary neoplasm but are supplemented by judicious use of the vascular studies, such as venography, angiocardiography and aortography.

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The Cytologic Examination Of Sputum And Bronchial Secretions

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MUCH has been written concerning pulmonary cytology. The bulk of the published material on the cytologic method of diagnosing carcinoma of the lung has been written for the cytologist, the pathologist and the lung specialist.

Although fragments of tumor were described in the sputum by Walshe[1] as early as 1843, it remained for Papanicolaou and Traut,[2] in 1943, to develop a dependable technic for examining exfoliated cells for cancer diagnosis. The following year Wandall's[3] classical monograph on pulmonary cytology was published. Since that time the method has been used extensively throughout the civilized world. In spite of its wide application and demonstrated effectiveness in large clinics and centers, there is ample room for expansion and improvement in many areas. The dissatisfaction with cytodiagnosis of sputa and bronchial secretions that I have heard expressed from time to time cannot condemn the soundness of this method of cancer diagnosis but rather is related to a breakdown in the technic, often beginning with improper collection and handling of the specimen.

It has been reported that up to 90 per cent of lung cancer can be diagnosed when three or more satisfactory deep cough specimens are submitted for examination.[4] Spjut and his colleagues[5] have shown that sputum tests were positive in 57.8 per cent of patients with lung cancer and in 76.6 per cent of those who had three or more tests. In 59 operable cases the cytology was the only positive tissue examination prior to operation. There were no false positives. Cahan[6] also has reported a similar experience in which there was confirmation of all positive cytologic diagnoses. The addition of cytologic examination to bronchoscopic biopsy, in the experience of many observers,[7] has added an increment of 30 to 40 per cent. Such striking results are dependent on (1) obtaining satisfactory diagnosable material for examination and (2) the efficiency of those doing cytodiagnosis. Close cooperation between the cytopathologist and the clinician is imperative for best results.

The Specimen

A sputum sample for cytodiagnosis is a pathologic specimen. Like any other pathologic specimen submitted for microscopic diagnosis, the correct interpretation cannot be made on an improperly obtained and prepared specimen. The more ideal the specimen, the more accurate the diagnosis. In our laboratory we have found the proper collection of the sputum specimen to be our greatest problem. Any procedure as simple as obtaining a sputum specimen usually is relegated successively down the line to the most inexperienced personnel available. Often the responsibility for collection of the specimen is assigned to a ward helper, the patient's relatives, or a visitor. Frequently the specimen is only saliva mixed with tints of tobacco juice, food, or medication. The time lapse from the "spitting" until the specimen reaches the laboratory may be unduly prolonged, permitting growth of bacteria and the occurrence of cytolysis. Specimens from the clinics often arrive via the bacteriology labora-

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tory. It actually is a waste of time to process and examine delayed specimens, and if we can predetermine the sequence of events, we no longer do so. An exerted educational program and strict rules for acceptance of sputum by the laboratory have greatly reduced the number of unsatisfactory specimens and thus increased the accuracy of the test.

A deep cough specimen, obtained preferably early in the morning, usually will contain many exfoliated cells in the mucous secretions collected in the bronchi overnight. We prefer the material to be obtained before breakfast. It should be collected in a clean petri dish and sent *immediately* to the laboratory with proper identification. A minimum of five labeled slides then are prepared, selecting the bloody or otherwise suspicious areas of the specimen and avoiding saliva, if it is present. The slides are placed immediately in a Coplin jar containing ether and 95 per cent ethyl alcohol in equal parts. Physicians collecting specimens in their offices often prefer to prepare the slides and fix them immediately. The slides then may be delivered to the laboratory at their leisure. Care should be exercised to identify the patient by writing his name on the slide and on the Coplin jar or bottle containing the fixative. Although we prefer this method of obtaining fresh specimens, it sometimes is not practical for the ambulatory patient. The alternative method is to provide the patient with a labeled bottle containing 70 per cent ethyl alcohol and give him careful instructions how to collect his own deep cough specimen. After expectorating into the bottle, it is important that the bottle be shaken, to insure full contact with the alcohol. Then the specimen can be delivered to the laboratory for processing. It is worth while to emphasize that the yield will increase with the number of specimens examined. On occasions we have found persistent positive specimens after two or more negative examinations.

Bronchial Washings

Herbut and Clerf[8] have had amazing success with bronchial washings; however, it is my opinion that most people, including ourselves, have had greater success with sputum. There are, nevertheless, definite advantages to bronchial washings. They can be useful in identifying the lung, lobe, or at times, the segment involved. They are relatively free from extraneous cells and debris and are thus more easily examined. Certainly in the case of the bronchoscopic specimen there is no valid reason for delay in preparation of the slides. One of the common methods used in the collection of washings or secretions is a trap connected to suctions. This method gives better results if no saline is used and the material is quickly smeared.

We have improved our yield of positive diagnoses by embedding the residual bronchial secretions or sputum in the same manner in which a biopsy would be handled and then examining multiple sections stained with hematoxylin and eosin. This, at times, provides clumps of cells and leads to the identification of the specific type of tumor.

The Laboratory

The interpretation of cell studies is no different than any other microscopic interpretation made by the pathologist; such diagnoses are largely subjective. All too often we hear that "the laboratory made the diagnosis of cancer." A laboratory cannot make a diagnosis of cancer. Such a diagnosis must be made by a well trained individual. The accuracy of the results then, assuming that the specimen is adequate, depends on the interest, experience and ability of the cytopathologist. Cytology, as generally practiced, is by no means perfect; but as experience increases, results are improving and, in my opinion, will continue to improve.

The laboratory must be well equipped. It must have well trained cytotechnologists who prepare the material in the best possible man-, ner, with special attention to the prevention of mixed identity of the slides and to contamination by cells from another case. An error in technic can lead to a false-positive diagnosis. Although there has been some objection voiced to non-medical personnel screening cells studies, my opinion is that this is essential. A well-trained screener will look at every cell on every slide, noting and marking any abnormal ones. This is a tedious and time-consuming task that few busy pathologists have

time to perform. It is my opinion that the cytotechnologists in our laboratory are less apt to overlook abnormalities than I am. In a large series reported by Foot[9] a careful check revealed only one instance of malignant cells being overlooked by the screener. With the negative smears eliminated, we then have much more time to spend on the abnormal ones. Our technic is improved by the fact that we must justify to our technicians any change in interpretation that we make. For example, we must explain to them why we disregard cells that they may have marked malignant.

The cytopathologist who is responsible for the final diagnosis must, of course, have a thorough knowledge of the normal cell types encountered in the respiratory tract. Often he can recognize at a glance a satisfactory specimen that has been produced by deep cough, by the presence of carbon-laden macrophages. When these cells are absent and the specimen is loaded with squamous epithelial cells from the mouth, he knows that the specimen is saliva and that further investigation of it will likely be fruitless. He must be familiar with the abnormal but nonmalignant cells present in infections, bronchiectasis, tuberculosis, lipoid pneumonia, et cetera. In this latter group of diseases, cells which can be confused with cancer cells frequently exfoliate from the bronchial mucosa. For example, the "Pap" cell (figure 3) found in inflammation also may be found in metaplasia and epithelial atypias associated with cancer. It is obviously important to avoid false-positive diagnoses. It is likewise important to maintain a reasonable yield of positive diagnoses on specimens from patients with cancer.

General Remarks

The criteria for diagnosing malignant cells are essentially those used in diagnosing cancer in other sites, such as the cervix uteri. However, unlike the cervix, which is easy to biopsy and must always be biopsied for a definitive diagnosis, the bronchus harboring the tumor may well be inaccessible to the bronchoscope and the advisability of thoracotomy will have to depend solely on the cell study. The gravity of the responsibility for cellular diagnosis is then considerably greater than in the case of cervical or vaginal cell studies. It behooves one to have as exacting criteria as possible and, when not sure of one's grounds, to render a diagnosis less than positive. For this intermediate group we use the term "suspicious," and repeat studies often solve the problem. Certainly all studies showing suspicious cells should be repeated. Most cytopathologists would take a conservative approach to the diagnosis of lung cancer and prefer not to base the diagnosis on the single isolated cell. The most conclusive evidence is afforded by cell clusters or, occasionally, fragments from the tumor. It is even possible to determine the cell type in many cases.

The methods of reporting used by different laboratories vary. We utilize three categories: negative, suspicious, and positive. This applies only to the satisfactory smears. As mentioned before, a considerable number are unsatisfactory for reasons already discussed. These latter ones should be reported as unsatisfactory and repeated immediately. It is deplorable that the request for a repeat often is ignored or the repeat greatly delayed. Foot[9] reports that the delay in repeating examination of suspicious sputa was usually about a month and occasionally as long as six months. Our experience has been similar to his. Unfortunately, according to our records a number never were repeated. The ease of procuring a sputum specimen makes this failure to repeat the examination difficult to understand—in fact, indefensible.

Pulmonary cytology thus far has been applied to the symptomatic patients who are suspected of having cancer. Facilities for large scale screening have not yet been fully developed. The individual without a productive cough is handicapped in producing a satisfactory specimen. On the other hand, the asymptomatic individual is the one most apt to harbor a curable cancer. The small lesions are the ones most often satisfactory from the cytologic point of view, since these tumors rarely are the site of extensive necrosis, hemorrhage and infection. Various technics of procuring sputa are being tried. One of these reported to produce a satisfactory specimen from virtually anyone seems to be promising. An aerosol pump nebulizes heated hypertonic saline and propylene glycol. The patient inhales

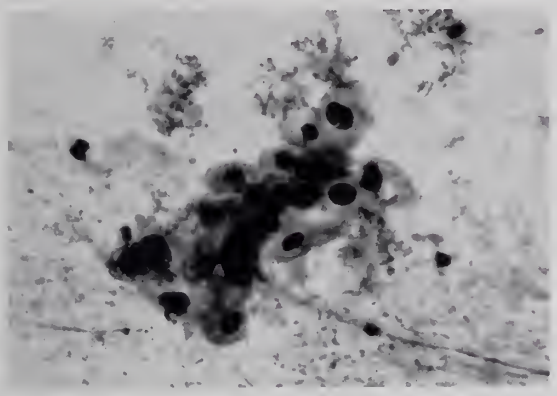


Figure 1
Malignant cells in sputum. Class V.

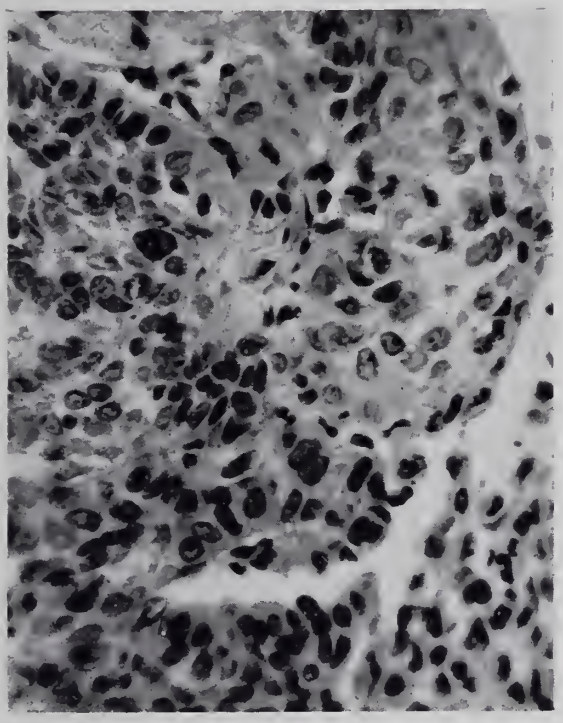


Figure 2
Epidermoid carcinoma of bronchus. Malignant cells are detached and free in the lumen. Note the similarity to the cells from his sputum sample, Fig. 1.

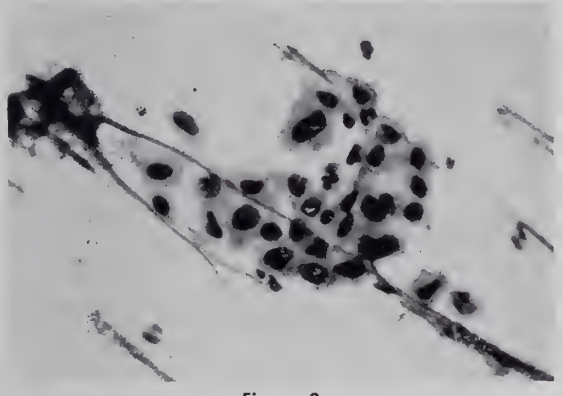


Figure 3
Abnormal, but nonmalignant cells in sputum of man with chronic pulmonary infection. Note the superficial similarity to the malignant cells in Fig. 1.

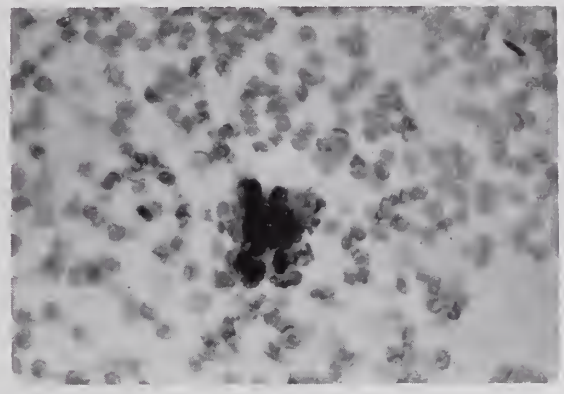


Figure 4
Malignant cells from bronchial aspiration. The cells are small, but the nuclei are hyperchromatic and irregular.

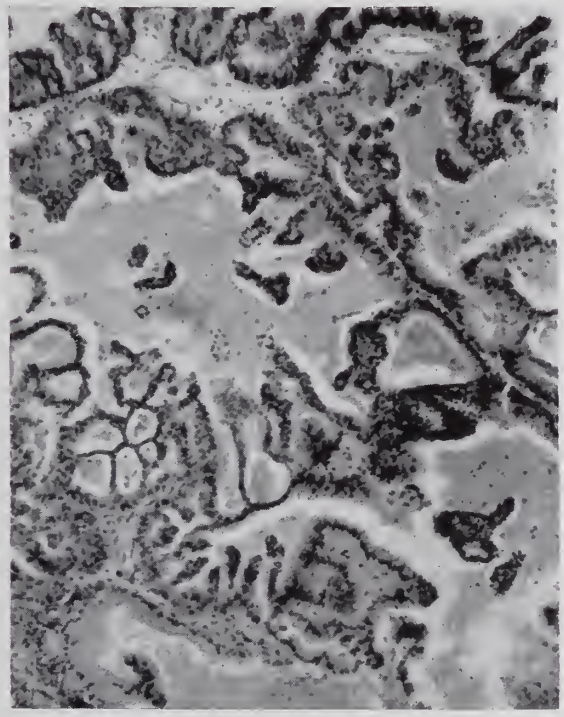


Figure 5
Piece of tissue in cell block from same patient as Fig. 4. The tumor is a well differentiated adenocarcinoma.

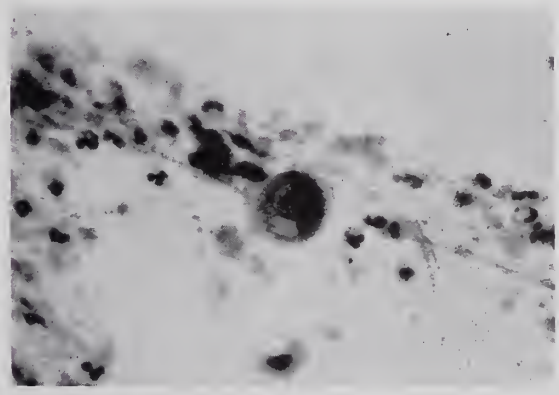


Figure 6
Isolated malignant cell from sputum of a woman later proved to have an epidermoid carcinoma of the bronchus.

the vaporized solution and soon begins to cough. It is reportedly not unpleasant and produces a superior type of specimen.[10]

I am hopeful that the cytologic examination, combined with periodic chest x-ray examination, of high risk adults will provide an effective screening method that will improve the survival rate from this dreadful disease.

Summary

The cytologic method has proved its effectiveness in diagnosing carcinoma of the lung. If three satisfactory sputum specimens are obtained, the reported rate of positive diagnosis in some large medical centers is as high as 90 per cent. The rate of false-positive diagnoses approaches zero.

Although sputum specimens can easily be obtained, our greatest problem over the years has been the extremely high incidence of unsatisfactory specimens submitted to the laboratory. The reasons for this and recommendations for correction have been discussed.

There still is often a great delay in submitting, or failure to submit, repeat specimens for examination when the first specimen is inconclusive or suspicious.

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The Role Of Endoscopy In The Diagnosis Of Carcinoma Of The Lung

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THIS discussion concerns itself with the possible role of bronchoscopy in establishing the diagnosis of carcinoma of the lung and selecting operable patients with this disease. It seems important to indicate that bronchoscopy can play an important role in the management of these patients but that, admittedly, it has limitations.

Advantages and Limitations

The advantages of bronchoscopy are that: (1) it is a relatively minor procedure that can be done under topical anesthesia, (2) it can be done as an outpatient, (3) it affords a direct study of the mucosa, (4) it allows one to obtain secretions for further examination and also to biopsy lesions that appear suspicious, and (5) it aids, at times, in determining the feasibility of operation. In addition, bronchoscopy permits the examiner to identify any other disease or deformity that may be present in the bronchial tree.

There are definite limitations to bronchoscopic examination. It is a well established fact that lesions in the periphery are not within view of the bronchoscope and therefore cannot be seen directly. This is true also in the secondary divisions of the bronchi. However, it is possible to obtain secretions from the secondary bronchial divisions, although they cannot be directly visualized. About 60 per cent of carcinomas of the lung are located in the upper lobes and therefore are less accessible to bronchoscopic examination and biopsy. The presence of other disease may obscure or alter the appearance of the neoplasm to a degree that the identification of the tumor at times may be uncertain. The secretions produced as a result of other disease may decrease the value of the aspirated material to be used for further study. The examination of secretions obtained by the use of the bronchoscope will be rewarding only if one has available an experienced cytologist and pathologist to study the cells found in these specimens.

Routine for Bronchoscopy

At St. Elizabeth Hospital in Covington, Kentucky, the routine which we follow in the majority of patients who undergo bronchoscopy is as follows. The patient is admitted to the hospital the afternoon preceding the day of endoscopy. Routine blood counts and urinalysis are obtained, if they have not been done within a short period of time before admission. In addition, any indicated special studies, such as blood chemistries, electrocardiograms, or further x-rays, are done on the afternoon of the patient's admission to the hospital. He receives nothing by mouth after midnight. We administer 0.1 gm. of sodium pentobarbital at bedtime and again the following morning, approximately 1½ hours before the patient is taken to the operating room. Thirty minutes preoperatively he is given 60 mg. of codeine phosphate hypodermically. The majority of our examinations are done under a topical anesthetic. In certain cases where special indications exist we do the examination under general anesthesia, although we do not feel that

this is as satisfactory and it increases somewhat the risk of the procedure.

The operating table is placed in the goiter position with the foot rest applied. The table is kept in the horizontal position and the patient is seated on the table with his legs over the side facing the operator. It is usually necessary to reassure the patient again and explain some of the steps involved, in order to secure his full cooperation during the examination. The following sterile equipment is included on a Mayo table near the operator: An atomizer, a Jackson laryngeal forceps, cotton, a laryngeal mirror, a 2-ml. Luerlock syringe, an Abraham flexible cannula, a medicine glass and topical 5 per cent hexylcaine hydrochloride (Cyclaine).

Preliminary Preparation

The operator then adjusts his headlight to a suitable position, performs a surgical scrub in the routine manner, dries his hands and dons a surgical gown and gloves. The patient is then asked to hold an emesis basin in his lap with one hand and with the other hand to hold the protruded tongue, using a 4 by 4 inch gauze sponge. If the patient is unable to do this, the nurse is asked to assist him. It is always wise to have a nurse or orderly stand behind the patient, to support and assist him if necessary. With the patient's mouth open wide and the tongue protruded and held, careful examination of the mouth, gums, teeth, and hard and soft palate is carried out. It should be noted while talking with the patient if there is any hoarseness. The mouth, uvula and pharynx are then sprayed with hexylcaine hydrochloride (5 per cent) with the atomizer. The patient should be instructed in advance not to swallow the medication but to expectorate it into the emesis basin. We feel that some serious reactions may result if excess anesthetic agent is allowed to enter the gastrointestinal tract, where it can be quickly absorbed. We have encountered no untoward reactions using Cyclaine. Next, the cotton is placed on the Jackson laryngeal forceps, immersed in the anesthetic agent, and then carefully applied to the pyraform sinus on each side. This directly affects the nerve endings of the pharyngeal plexus, which is composed mainly of fibers of the ninth and tenth nerves. The laryngeal mirror then is warmed sufficiently by holding it against the buccal mucosa. Using the mirror, the examiner can visualize the pharynx and larynx and study the anatomy and movements of the vocal cords. If any abnormalities are noted, it is wise to laryngoscope the patient prior to bronchoscopy.

After the examination has been done with the mirror, 1 ml. of anesthetic agent is withdrawn into the 2-ml. syringe, to which the Abraham cannula has been fixed. With the epiglottis and cords visualized through the mirror, the 1 ml. of anesthesia is placed between the cords as the patient takes a deep breath. He is then asked to lean first on the left elbow and then on the right, and each time another 1 ml. of anesthetic agent is placed between the cords during deep inspiration. Time and care should be taken to obtain satisfactory anesthesia, since it will contribute much to an adequate examination. A total of 5 to 7 ml. of anesthetic solution is used.

The Examination

The patient is then placed in the supine position on the operating table, the operating room lights are dimmed, the foot support is adjusted and the table is placed in the goiter position. A sterile towel is placed about the patient's head, covering the hair and eyes, and is held in place with a towel clip. A sterile sheet is placed over the patient, from the neck down. If necessary, a laryngoscope is then introduced and a laryngeal examination performed. However, if no pathologic lesion in the larynx is suspected, this portion of the examination is omitted and direct bronchoscopy is carried out. In adults we usually prefer to use an 8 by 40 mm. bronchoscope for men and a 7 by 35 mm. bronchoscope for women. Our preference is the Jackson full-lumen type of bronchoscope. The head-rest portion of the table is then released a few notches and the patient is asked to open his mouth widely. The bronchoscope is then carefully introduced with some forward pressure against the tongue, usually from the left corner of the mouth. As the bronchoscope is gently advanced forward, the thumb is placed beneath it to guide it and maintain the proper tension against the tongue. With the patient's

head rotated slightly to the right, the bronchoscope glides by the epiglottis to the larynx. When the vocal cords are visualized, they can be seen to open on inspiration, and the bronchoscope can be easily introduced through the larynx into the trachea. Force never should be exerted. If the cords are opposed, wait patiently and they will open when the patient takes a deep breath. The bronchoscope then is slowly passed down the trachea, which is carefully studied. The main carina, indicating the tracheal bifurcation, is then identified. Its position, sharpness and texture are noted.

Collection of Aspirate

We routinely examine first the side thought, from previous examinations and studies, to be normal. The mucosa is examined for evidence of hyperemia, ulceration, nodularity, or fixation. Each of the orifices of the lobes and segments is identified and abnormalities are noted. The amount and characteristics of secretions also are noted and secretions from the normal side may be collected, using a 40 to 50 cm. Jackson aspirating tube and a Luken's collecting tube. The Clerf specimen collector also may be used, if preferred. The aspirator and collector tube used on the one side then is changed for a clean, sterile set to be used on the opposite side. Any suspicious lesions, even on the normal side, should be biopsied. The bronchoscope is then withdrawn to the main carina and the opposite side is examined. Here the examination is done in the same manner as described above but with some additions. After routine examination, collection of aspirate again is carried out; but here the Tucker aspiration tube with the flexible tip, either straight or curved, will be of value. Aspirate then can be collected directly from the lobe or lobes suspected. Further information may be gained by introducing the Broyles telescope lens. We have found the right-angle examining telescope the most useful. Any suspicious areas may be wiped with a Jackson bronchoscopic sponge on a Jackson sponge carrier and the material placed on the slides and immersed immediately into the alcohol-ether solution for Papanicolaou smear, or a direct biopsy may be taken. Throughout the procedure it is best to aspirate frequently to remove secretions or blood for better visibility. We prefer the angular cup biopsy forceps in most instances. If bleeding persists after biopsy, a bronchoscopic sponge dipped in 1:1000 topical adrenalin solution may be applied to the bleeding surface for a few minutes, which usually controls the bleeding.

Bronchography

Bronchography is another diagnostic procedure available to us. This involves the instillation of a radio-opaque substance into the tracheobronchial tree. Our choice of contrast medium is 10 per cent Dionosil (oily). We feel that bronchography should be a separate procedure and should not be performed on the same day as bronchoscopy. We have attempted on several occasions to instill oil into the bronchial tree through the bronchoscope and have found this to be a highly unsatisfactory procedure. Despite the cooperation of the radiologist and the patient, we invariably are faced with incomplete filling or alveolar flooding. Instillation of the medium through a rubber catheter which has been inserted through the nose into the trachea of a patient who has been anesthetized as outlined above has yielded better results for us. This procedure is best done in the x-ray department where the patient also can be anesthetized. After the catheter has been placed in the trachea, it is guided first to the right side and 20 ml of the medium is instilled and the patient is placed in various positions to completely fill this side only. Fluoroscopy is then done to determine the adequacy of segmental filling. Spot films may be taken, if desired. We routinely obtain a PA, right lateral and left anterior oblique view, to better demonstrate the middle lobe. Using the fluoroscope, the catheter is then guided into the left side and 20 ml. of the medium is instilled. Positioning again is carried out and fillings checked by means of fluoroscopy. We then obtain a PA and right anterior oblique views. We feel that complete filling is most important in this diagnostic procedure, not only to outline complete blockage by a neoplasm but also to demonstrate narrowing or distortion of adjacent bronchi. In certain instances where bronchoscopy has failed to be helpful, this procedure has led to the correct diagnosis, particularly of

lesions in the upper lobe. It can be helpful also in predicting the extent of resection.

Results

A review of the literature reveals considerable variation in the diagnosis of carcinoma of the lung by means of bronchoscopy. The reports vary from 35 to 85 per cent, but most authors agree that the average is approximately 40 per cent positive biopsies. Some investigators state that cytologic study greatly enhances the diagnostic value of bronchoscopy. When biopsy and cytologic smears are combined on multiple examinations, some investigators report that positive diagnoses can be obtained in 80 per cent of patients studied.

We have reviewed the results of the bronchoscopies done in our hospital during the period from 1954 through 1958. We performed bronchoscopies on 121 patients who had symptoms or findings suggestive of carcinoma of the lung. Of these 121 patients, 44 subsequently were proven to have carcinoma of the lung at operation or autopsy. Of the 44 patients with proved carcinoma of the lung, 18 had positive biopsies and in 5 the aspirate was reported as positive. In 2 cases both the biopsy and the cytologic study of the aspirate obtained through the bronchoscope were positive. In other words, we experienced a 55 per cent positive rate of diagnosis on our patients using the bronchoscope for diagnosis of carcinoma of the lung. These results lead us to conclude that bronchoscopy is of a considerable value as a diagnostic procedure in these patients. In addition, bronchoscopic examination enables one to determine the extent of the lesion. In 2 cases operation was not done because the tumor was found to encroach on the patient's main carina and to grow into the trachea or toward the main stem bronchus on the opposite side.

Summary

One-hundred twenty-one patients were studied for possible lung cancer by bronchoscopic examination, biopsy and aspirate. Forty-four patients of this series subsequently were proved to have had lung cancer. Eighteen positive biopsies were obtained, five positive aspirates, and in two cases both biopsy and aspirate were positive. This represents a total of 55 per cent positive bronchoscopic diagnoses. In addition, bronchoscopy enables one to determine the extent of the lesion. Bronchography also is of value at times in the diagnosis of carcinoma of the lung.

It is the first step in sociological wisdom, to recognize that the major advances in civilization are processes which all but wreck the societies in which they occur:—like unto an arrow in the hand of a child. The art of free society consists first in the maintenance of the symbolic code; and secondly in fearlessness of revision, to secure that the code serves those purposes which satisfy an enlightened reason. Those societies which cannot combine reverence to their symbols with freedom of revision, must ultimately decay either from anarchy, or from the slow atrophy of a life stifled by useless shadows.

—*Whitehead*

SYMPOSIUM

Surgical Management of Malignancy of the Lung

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THE initial success of pulmonary resection for carcinoma of the lung was achieved in 1933 by Graham and Singer.[1] A squamous cell carcinoma was removed from a fellow physician by complete pneumonectomy. This operation was accompanied by no serious complications. The patient has continued a long, healthy life as a physician. In a recent communication Blade[2] reviewed this case and substantiated the diagnosis, thus dispersing rumors that in reality the lesion had been an adenoma. Rienhoff and Broyles[3] and Churchill and his colleagues[4] performed pneumonectomies for carcinoma within the year. Rienhoff and Broyles' technique was more refined and approached to a greater degree the present day concept of hilar dissection with individual ligation of the great vessels.

Techniques Perfected

The surgical treatment of carcinoma of the lung gained immediate and widespread acceptance following Graham's report. Prior to 1933 there had been no reported cure of carcinoma of the lung. Subsequently techniques were perfected, increasingly large series of cases were reported, and factors which influence the salvage rate became appreciated. Despite many advances in roentgenology and chemotherapy, surgical removal remains the most effective method of dealing with this disease.

Factors which influence the successful treatment of carcinoma of the lung are: (1) The cell type of malignancy, (2) the presence or absence of direct invasion of contiguous structures, (3) the presence or absence of lymph node metastasis, (4) the question of angioinvasion, (5) the anatomical location of the tumor, (6) the presence of distant metastases, and lastly, (7) the otherwise indeterminate host-tumor relationship. Other more indirect factors are: (1) the time interval between onset of symptoms and consultation of the physician, (2) the delay between initial medical care and consultation with the thoracic surgeon, and (3) the status of the pulmonary physiology of the patient.

Surgical Philosophy

In order to fully understand the current surgical philosophy toward carcinoma of the lung, the above-mentioned factors should be amplified. The phrase "surgical philosophy" may well need definition. Perhaps in no other single surgical problem does the operator need to develop as aggressive an approach, tempered, however, and mindful of certain important factors. These factors include the knowledge of the need to balance pulmonary function, a consideration of the patient's age and the postoperative disability, and an appreication of the possibility of immediate operative dangers resulting from hemorrhage. It is my conviction that the thoracic surgeon must approach the problem of carcinoma of the lung without fixed ideas. He must be aware of the limitations of the several types of resection and must evaluate his patient's ability to carry on after the resection. He must be aggressive in his plan to resect the malignancy, yet must control his zeal sufficiently that the benefit the patient is to derive from the operative procedure will be worth the risk and discomfort. Three factors that may modify one's operative plan before thoracotomy are: (1) The patient's pulmonary function, (2) his age, and (3) the presence of associated disease.

Pulmonary Function

Pulmonary function studies are instructive, but are not always essential in the successful treatment of these patients. Careful interrogation of the patient with regard to his work load

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and his physical stamina often are all that is needed to assure that he may successfully undergo pulmonary resection. A history of dyspnea should make the surgeon aware that he may have to limit his proposed resection. It is in this type of patient that pulmonary function studies, including a timed vital capacity and maximum breathing capacity, are indicated to properly evaluate the patient. Age is an index to emphysema, since individuals in the older age group are more likely to suffer from this complication. In my experience, individuals over 70 years of age are not likely to tolerate pneumonectomy well, because the remaining lung is too emphysematous and inelastic to accommodate the full work load. A pneumonectomy in such a patient may result in a pulmonary cripple.

Associated Diseases

Among the important associated diseases that influence surgical judgment in dealing with carcinoma of the lung are cardiac, hepatic and renal diseases. Poor cardiac function will impose a restriction on the amount of functioning lung tissue that one may safely resect. If cardiac failure develops, it is an unfortunate sequela of pneumonectomy. Likewise, aggravation of preexisting hepatic or renal disease will seriously interfere with the patient's postoperative convalescence. Careful consideration of the above factors has led an increasing number of thoracic surgeons to the realization that lobectomy in selected cases is the procedure of choice. Lobectomy also may be wisely employed in certain other instances to be discussed later.

After the surgeon has determined the operability in a given patient, he must then direct his attention to the type of procedure that is indicated. The procedure will vary with the type of pathologic lesion. Malignancy of the lung may be conveniently classified as (1) adenoma, (2) carcinoma (primary or metastatic), or (3) lymphoma.

Adenomas

Adenomas are slow growing and remain localized for long periods of time. In some respects an adenoma resembles an iceberg, presenting itself as a small nodule in the bronchus. Adenomas may at times be removed by the bronchoscopist, provided he can control the bleeding. In the past, leading bronchoscopists have advocated local removal as curative. However, experience has shown that these tumors extend for some depth beneath the bronchial mucosa. If only partially removed, they may be as lethal as any other malignancy of the lung. They lend themselves readily to resection, and the cure rate is in the order of 90 per cent. As a rule, lobectomy is a satisfactory procedure. However, on occasion the anatomic location of an adenoma may necessitate more extensive resection.

Carcinomas

Carcinoma of the lung may be squamous cell, small cell, large cell, adenocarcinoma, or alveolar cell. The squamous cell carcinoma yields the highest salvage rate. The small and large cell tumors have a greater propensity for rapid local dissemination and metastasis via the lymphatics. Adenocarcinoma seems to have a high rate of angio-invasion. The recovery rate with adenocarcinomas is quite low. The cell type of all of these tumors is of little importance at the actual time of surgery. One's attitude and actions then will not be materially changed by the pathologic morphology. Not so with the alveolar cell carcinoma. This tumor, which is believed to arise within the alveoli instead of from the bronchial tree, is often multicentric in origin. Evidence is accumulating that one method of spread is bronchogenic. Lobectomy, when feasible, offers a satisfactory method of treatment. Surgical resection of certain metastatic pulmonary lesions appears to be justified by the number of cases that have been successfully treated. The primary site of this type of metastatic lesion is most often a renal tumor or sarcoma of the bone or soft tissue.

Lymphomas

Since lymphomas of the lung usually are a manifestation of systemic disease, one should carefully select these cases for resection. In those instances in which the lymphoma is localized to the lung, they lend themselves well to surgical resection and the recovery rate is high. Unfortunately, only a small portion of lymphomas are localized.

Operability

It is unfortunate that a high percentage of patients with pulmonary malignancies must be considered inoperable at the time of surgical consultation. Many competent investigators agree that only about 55 per cent are inoperable.[4,5,6] The following conditions are absolute contraindications to surgical resection: (1) Distant metastases; (2) positive, although not necessarily palpable scalene nodes; (3) evidence of vertebral erosion; (4) Horner's syndrome; (5) phrenic and recurrent nerve involvement; (6) pleural effusion which contains malignant cells. In certain cases the following factors may, but do not necessarily, contraindicate an attempt at surgical resection: (1) Pleural effusion without malignant cells, (2) either phrenic nerve or recurrent nerve involvement, (3) rib erosion, (4) evidence of mediastinal fixation on bronchoscopy, (5) evidence of tracheal spread on bronchoscopy, (6) vena caval obstruction.

The Categorically Inoperable

In my opinion, those patients classifed as categorically inoperable will obtain greatest benefit from treatment by methods other than surgery. Those indivduals who fall into the second group above also will, for the most part, be found inoperable. Rarely, operation may prove beneficial to patients included in this latter group. In many, operative procedures will prove to be only palliative. Occasionally one may encounter a patient with pleural effusion which contains no malignant cells and which is due to atelectasis and pneumonia behind the centrally located carcinoma. If the cytologic examination of the pleural fluid proves negative for malignant cells, exploratory thoracotomy may be justified. On occasion, the involvement of the phrenic nerve may be a direct pericardial extension which can be resected, in which case exploration is justified. The same may be said, but to a lesser degree, with regard to involvement of the recurrent nerve. Rib erosion is not an absolute contraindication to exploration, particlarly if there is no involvement of the first or second rib or of a series of ribs at their vertebral ends. Involvement of these latter areas implies bracheal plexus extension and invasion of vertebral bodies.

Mediastinal fixation observed at the time of bronchoscopy is difficult to describe. The bronchoscope does not respond well to manipulation and may feel as if it is in a fixed position. Such fixation indicates massive mediastinal invasion and, when encountered by the experienced bronchoscopist, will be considered a contraindication to surgery. This is one reason why, in my opinion, the operating surgeon should perform his own bronchoscopic examinations, rather than rely on another examiner's opinion concerning the matter of mediastinal fixation. Involvement of the trachea need not be an absolute contraindication to operation. If the area involved is small, which can be determined by multiple biopsies, one is justified in attempting to remove part of the trachea. Tracheal respiration can be accomplished, using suitable foreign material. Vena caval obstruction is no longer considered an absolute contraindication to surgery, unless laminograms and angiograms reveal that there is massive involvement of the mediastinum. Resection of the vena caval segment for the removal of a localized lesion can be accomplished.

Resectability

Once the decision has been made to perform thoracotomy, what renders a case nonresectable? Despite all preoperative studies indicating resectability, one frequently finds, on opening the chest, that the lesion is impossible to remove. Frequently solid sheets of cancer encase the hilus, obliterating all landmarks and infiltrating the great vessels. At times bony invasion is present which was not recognizable by means of the preoperative studies. Such conditions render resection impossible and account for the fact that one-third of the patients operated on ultimately do not have resections. Nevertheless, at the time of surgery tissue can be obtained which may yield valuable information to the radiotherapist or chemotherapist. Also, the lesion can be outlined with silver clips, which will enable the radiotherapist to more effectively treat the area postoperatively.

If the surgeon finds that the lesion is resectable, he must decide which type of surgical

procedure is most likely to be effective. The operation will fall into one of two categories: curative or palliative. I do not believe in palliative pneumonectomy. The operation risk, postoperative complications and physiologic loss are, in my opinion, too great to justify this procedure. The patient will do better with x-ray therapy and chemotherapy. However, I do strongly advocate palliative lobectomy. This procedure is worth while because it preserves functioning lung tissue and spares the patient considerable pain and postoperative complications.

When pneumonectomy is performed to effect a cure, the surgeon must be sanguine. If only local spread has occurred, he must be radical and attempt to resect all of the malignant area. Modern techniques make possible the replacement of blood vessels and other vital structures, such as portions of the pericardium, heart wall, vena cava and aorta. Lobectomy is often curative when one is dealing with small lesions in the periphery. However, the resection should include all hilar lymph nodes.

Types of Pneumonectomy

There has been considerable discussion concerning the most effective type of pneumonectomy. Cahan et al[7] and Watson[8] advocate a radical mediastinal node dissection with stripping of the trachea and great vessels. Johnson et al[6] and others[9] feel that, because of the rich and interlocking lympatic system, such a procedure is not justified. Most thoracic surgeons take a middle course, removing with the lobe or the lung all hilar and all palpable mediastinal nodes. No effort is made to completely clear the trachea. Direct invasion should be vigorously attacked, when feasible, and here the true ability of the surgeon is challenged. Intrapericardial dissection and ligation of the great vessels is feasible, so that invasion of the great vessels and pericardium at the hilum may be removed. Localized tacheal, vena caval and aortic invasion may be resected with the specimen and appropriate reconstructive procedures carried out.

Intrapericardial Ligation

It has become my routine practice to perform intrapericardial ligation of the pulmonary vessels. It is my belief that this can be accomplished with greater ease than hilar dissection, and these hilar lympahtic areas are removed with the lung virtually intact. Another procedure that I have found of value is to cross-clamp and suture the pulmonary artery, which tends to be brittle in older individuals and has been known to rupture spontaneously after ligation. The cross-clamping procedure, with an atraumatic clamp and closure of the artery with a running-



Figure 1
Intra-pericardial ligation of vessels for carcinoma of the lung. Insert shows posterior lateral left thoracotomy incision. The black area represents the tumor invading the pericardium. An incision has been made in the pericardium across the phrenic nerve. The great vessels are visualized.

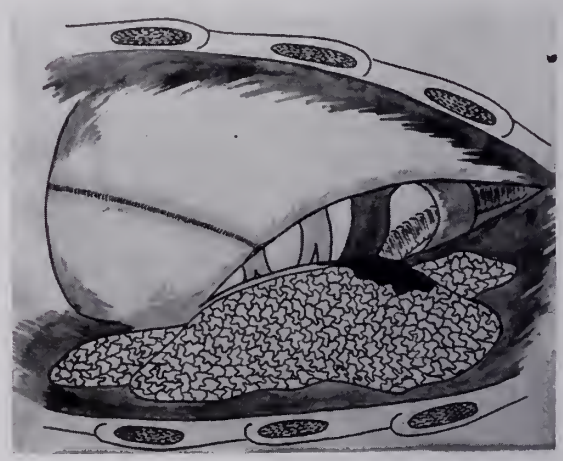


Figure 2
The incision has been further developed and one sees from below upward the pulmonary veins, inferior and superior, the pulmonary artery and the aorta.

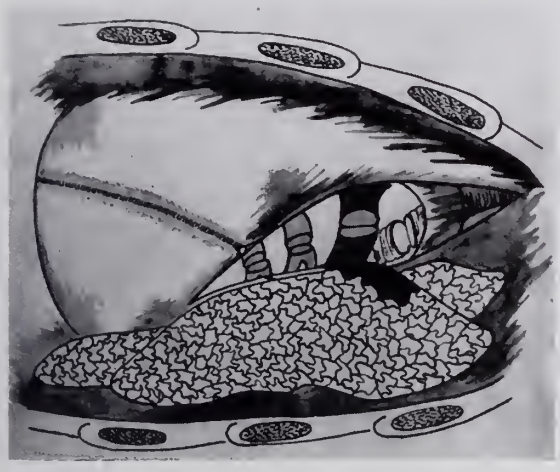


Figure 3
Here the level of resection of the vessels is indicated. Clamps have been left off the drawing for clarity.

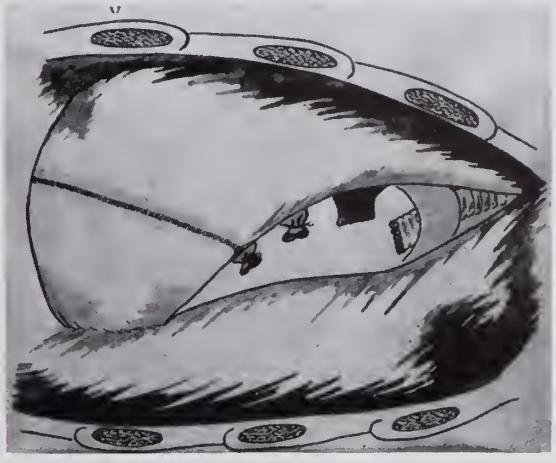


Figure 4
The lung has been removed. The trachea and pulmonary artery have been closed with sutures whereas the veins have been ligated. The pericardium will be loosely closed.

over-and-over arterial suture, in my opinion, will over a period of time prove of value. The intrapericardial ligation of great vessels provides a swifter and more effective method of pulmonary resection and, I believe, is safer than hilar dissection.

Resection of Bronchial Stump

High resection of the bronchial stump is very important. For example, squamous cell carcinoma often extends submucosally along the bronchial wall. Therefore, the higher the resection, the more likely the operator is to be beyond the area of extension. It is not uncommon for recurrence to occur at the level of the bronchial stump. Resection at the carina or at the main stem bronchus in patients undergoing lobectomy may result in a higher incidence of cure. In view of what has been said, I believe that the best method consists of intrapericardial vessel ligation, resection of the bronchus at the carina, and removal of all hilar and carinal nodes. All palpable nodes in the mediastinum should be resected and removed.

The fact that the cure rate is influenced by nodal metastases has long been established. However, recent studies reported by Coller et al[9] suggest that invasion of the veins by carcinoma plays an even more important role in the prognosis of an individual case. Angio-invasion is not difficult to demonstrate. According to these investigators tumors without venous invasion or lymph node metastases have a cure rate of approximately 85 per cent, whereas the cure rate in those with invasion is about 6 per cent. Although the presence or absence of angio-invasion is an important factor in prognosis, it should not alter the surgeon's attitude toward a given resection. If resection is possible under the previously listed criteria, the demonstration of tumor cells in the veins should not deter the operator from carrying out his planned procedure.

Postoperative Care

The postoperative care of the patient who has undergone a lobectomy differs somewhat from that of the patient who has had a pneumonectomy. Following lobectomy, the patient should have waterseal bottle chest drainage. He should be encouraged to cough in order to fill out the operative side with the remaining lung. Adequate coughing will obviate endotracheal suction and bronchoscopy for atelectasis. Occasionally thoracentesis for the collection of fluid may be necessary.

If the patient has undergone a pneumonectomy, the chest is not drained. During the postoperative period the patient is observed carefully for evidence of mediastinal shift. The trachea should be palpated frequently. The heart border should be percussed out, the rate of breathing recorded, and the patient carefully observed for any evidence of dyspnea or cyanosis. Air, when present, should be aspirated

from the operated side as often as necessary, although usually only one or two aspirations are required. Thoracoplasty for reduction of large, air-filled defects may be indicated to prevent over-expansion of the remaining lung. This may be done at the time of pneumonectomy or later. A five-rib thoracoplasty combined with section of the phrenic nerve usually is sufficient to obliterate the empty hemithorax and prevent any significant mediastinal shift.

Report of Cases

The following cases are presented to illustrate some of the foregoing concepts:

Case 1.—The patient was a 54-year-old white male who complained of pain in the right side of the chest of three months' duration. The x-ray of the chest revealed atelectasis of the right lower lobe bronchus. A biopsy revealed squamous cell carcinoma. At the time of thoracotomy the tumor was found to invade the inferior pulmonary vein, pericardium and auricular wall. Intrapericardial dissection was carried out, with removal of a large portion of the auricular wall by means of an atraumatic clamp. The specimen revealed a pedicle of tumor growing into the lumen of the inferior pulmonary vein, as well as into the auricular wall. The patient's recovery was uneventful. He was asymptomatic for fifteen months. Three months later (eighteen months postoperatively) he died of wide-spread metastases.

This case illustrates inability to effect a cure when angio-invasion is present at the time of operation.

Case 2.—The patient was a 73-year-old white male whose only complaint was recent loss of weight. A routine roentgenogram of his chest revealed a 2 cm. mass in the apex of the upper lobe of the left lung. A thoracotomy was performed. There was no gross or microscopic extension of the malignancy into the pleura. A left upper lobectomy was done, with resection of the hilar nodes. The pathologic diagnosis was squamous cell carcinoma with no angio-invasion. Likewise, microscopic examination of twenty-three lymph nodes revealed no evidence of metastasis. The patient's postoperative course was satisfactory and he regained his lost weight. There was no physiologic respiratory deficit. One year after the operation the patient was examined and found to have no evidence of recurrence.

This case illustrates the effectiveness of lobectomy in the management of lesions in the periphery, in the aged patient.

Case 3.—The patient was a 59-year-old white male who presented himself at the Clinic because a mass in the upper lobe of the left lung had been found on a survey roentgenogram of the chest. At the time of thoracotomy a squamous cell carcinoma which had invaded the pericardium and the pulmonary artery was found. An intrapericardial dissection was carried out, sectioning the pulmonary artery at its bifurcation (figures I through IV). The patient's postoperative convalescence was uneventful. He has now been followed for six months and to date has developed no evidence of recurrence.

This case is cited primarily to demonstrate the feasibility of the intrapericardial dissection.

Case 4.—The patient was a 42-year-old male, whose complaint was pain in the right side of the chest of three months' duration. He had been under treatment for "pleurisy." A roentgenogram of the chest revealed a small mass in the right upper lobe with erosion of the third and fourth ribs. At the time of thoracotomy the tissue diagnosis was squamous cell carcinoma. A left upper lobectomy was performed, with resection of a wide portion of the chest wall, including the second, third, fourth and fifth ribs. His postoperative convalescence was uneventful. Five years after the lobectomy the patient is alive and well.

This case demonstrates the feasibility of lobectomy combined with wide local excision in dealing with lesions of this type in the periphery.

Case 5.—The patient was a 50-year-old colored male who was referred from a tuberculosis sanatorium because of a large mass which had been found in the upper lobe of the right lung. Bronchoscopic examination was negative. At the time of thoracotomy a large squamous cell carcinoma was found. It had invaded the pericardium, pulmonary artery and vena cava. It was possible to carry out an intrapericardial dis-

section. An atraumatic clamp was placed across the superior vena cava and pulmonary artery. The specimen was removed, containing a portion of the superior vena cava and the pulmonary artery, both of which were involved with cancer. The two vessels were closed separately. Squamous cell carcinoma was demonstrated on microscopic examination of both the wall of the pulmonary artery and the vena cava. However, the lesion apparently was completely excised. When last seen, nine months postoperatively, this patient was alive and well.

This case again illustrates the value of intrapericardial resection and removal of contiguous structures.

Results

The question often raised: "What results can be expected from pulmonary resection? Approximately 25 per cent of patients who undergo resection will be alive in five years, without evidence of recurrence. This percentage is reduced, of course, when one considers that only 65 per cent of patients seen are candidates for surgical treatment. Moreover, of those who undergo operation, only 50 per cent will be resectable. The mortality rate in this group of patients is in the order of 10 per cent. In other words, of 100 consecutive patients seen, only 9 will be alive and have no evidence of recurrence in five years. This figure represents an average of several large series of cases reported.[4,5,6,7,9]

If the 9 per cent recovery rate is to be improved, there must be a high index of suspicion regarding this disease. The routine chest x-ray must be employed with greater frequency and regularity. Careful examination of the pulmonary tract is mandatory in any patient who has a persistent cough or an abnormal roentgenogram. Operation must be performed as early as possible.

Summary

The significant factors that influence the outcome of the surgical treatment of pulmonary malignancy have been discussed. The early recognition and the liberal use of roentgenograms and prompt surgical treatment offer the greatest chance of improving the recovery rate in carcinoma of the lung. Surgical removal is the most effective method of treating this disease. Lobectomy, when properly employed, is a satisfactory procedure in dealing with a large number of cases of cancer of the lung. Present methods of resection should result in an increase in the survival rate.

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The Use of Chemotherapeutic Agents and Roentgen Ray Therapy In Carcinoma of the Lung*

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THE rapid increase in the incidence of cancer of the lung is of great concern to the medical profession and the public alike. This increase has been reported in every state.[1] The problem is one of attempting to cure an advanced disease that has remained subclinical for a long period of time. The challenge is to develop an attack along the lines of prevention and discovery of the disease while it is still subclinical and curable. It would seem that in all patients with lung cancer there must be some common factor present which is triggered into the production of abnormal cell growth by some specific stimulus.

One of the most recent trends in the treatment of carcinoma of the lung is the use of chemotherapeutic agents. This is feasible since the anatomic location of the tumor permits it to receive a large portion of the intravenous dose of a chemotherapeutic agent. However, the value of (chloroethylamine) emthyl-bis has not changed since its introduction in 1946.[2] The exact reaction and effectiveness was described in detail by the Tissue Growth Committees[3] using the poison mustard gases for experimental trial in the laboratory. The official announcement of nitrogen mustard clearly stated that: (1) It was not considered a cure; (2) it exerted its greatest effect on growing tissue, normal or neoplastic; (3) its predominate toxic effect was on the hemapoietic system; (4) tumor regression was considered temporary; and (5) its effect was similar to that of x-ray therapy, the chief advantage of x-ray therapy being that it can be given locally. Of the several chemicals devised, nitrogen mustard (HN_2) has become the most useful. The usual practice is to deliver a calculated dose into the tube of a freely running intravenous solution of glucose-saline. Several procedures are in use. The accepted dose level is 0.1 mg. of HN_2 per kilogram of body weight ($D_4 = \frac{\text{Wt. lbs. x } 0.1}{2.2}$) daily for four doses. At times, for a single maximum immediately effective dose, 0.4 mg. of HN_2 per kilogram is used ($D_1 = \frac{\text{Wt. lbs. x } 0.4}{2.2}$). The latter is popular as a single dose method following surgery for lung cancer. However, 30 mg. is the maximum total single dose. The dose should be delivered in aliquots during the operation and completed immediately after the procedure. It is thought[4] that the time of exposure of the chemical to the circulating cells and the number of cells per milliliter of circulating blood influence the effectiveness. Experiments indicate that HN_2 is more effective than Thio Tepa (Triethelene thiophosphoramide). The procedure is to start the intravenous administration of some isotonic liquid (glucose-saline), using a fairly large caliber (#18) needle to establish a freely flowing solution. The Mustargen bottle is then opened and a measured amount of sterile water is flowed in quickly, with agitation to mix the desiccated HN_2. An aliquot representing the calculated dose is withdrawn into the same

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syringe and the portion is rapidly delivered into the tube of the intravenous set. The mixing of the HN_2 should be expedited because of the rapid decay of the gas in solution. The mixing and injection should be completed in 30 seconds. Long delay of the mixing procedure may account for poor response in some of the very sensitive tumors, such as lymphoblastoma.

Methyl-bis Program

A methyl-bis program was started in this department in 1947[5] and has proved useful. Best results have been attained in the treatment of lymphomas of the chest and the superior vena caval syndrome associated with bronchogenic carcinoma. The response in the latter syndrome is often dramatic. It appears that minimum tumor regression within one or two days relieves the critical pressure on the mediastinal vessels. The cyanotic, dyspneic, anxious patient, with dilated neck and chest veins, is extremely grateful for the immediate palliation. The use of Mustargen in the treatment of this condition was described in 1951 by Roswit and Kaplan.[6] On many occasions the primary tumor reduced noticeably in size within a few days after a single massive dose given immediately following operation or after the usual four-day serial dose. The massive dose is calculated at 0.4 to 0.5 mg. per kilogram of body weight, but not more than 30 mg. is given per single dose. Our experience suggests that bronchogenic tumors respond more completely and promptly when x-ray therapy is given immediately after adequate HN_2 therapy. At times, nitrogen mustard given before radiotherapy will deplete the red and white cells to such an extent that transfusions or a delay in therapy may be necessary. Hatch and his colleagues[7] have reported that patients who received multiple injections of HN_2 in a series of four doses achieved better and more lasting palliation than those who received single doses. Furthermore, it is believed that a combination of HN_2 and supervoltage x-ray therapy is much better than either alone. This has been the experience of several therapy centers where supervoltage has been available for several years.[8,9]

On the Thoracic Surgery Service of St. Joseph Infirmary the postoperative administration of intravenous HN_2 is employed frequently and is considered important.[10] Mustard gas first was used in this fashion in 1950, and the frequency of its use gradually has increased. Whereas it first was employed as an adjunct to radiotherapy only in inoperable cases, it now is given almost routinely after operative procedures for carcinoma of the lung. In addition, the pleural cavity occasionally is washed thoroughly at the time of operation with a weak solution of HN_2 (10 mg. per 500 ml. of H_2). Several other chemical agents recently have been described that are said to be suitable for the irrigation of wounds and cavities. Since it has become evident that contamination and seeding occur regularly in the pleural cavity during surgical procedures,[11] the use of this procedure has increased. For example, pleural washings were found to contain cancer cells in 13 of 28 patients on whom biopsies had been performed prior to lobectomy or pneumonectomy. In striking contrast, the pleural washings of only 3 of 21 cases were found to contain malignant cells where resection was not preceded by biopsy. This suggests that the advisability of biopsy prior to resection perhaps should be reconsidered.

Intravenous Chemotherapy

Recent investigations[12,13] lend support to the value of the routine administration of intravenous chemotherapy during the postoperative period. For example, as many as 15 to 20 circulating tumor cells per milliliter of blood have been demonstrated at the time of diagnosis of bronchogenic carcinoma. During a surgical procedure 60 to 80 cancer cells per milliliter have, at times, been found. The monitoring of the blood stream cells has been simplified to a degree by a new lysing and filter technique, so that samples of blood may be analyzed at various periods during examination and operation.

A recent survey[14] was made of the patients with cancer of the lung admitted to St. Joseph Infirmary from July of 1957 to December of 1958. During this eighteen-month period, there were 40 admissions, 37 males and 3 females. Thirty-two of these

patients had squamous cell carcinoma, 3 had adenocarcinoma, and in the remaining 5 patients the carcinoma was not classified because the diagnosis was clinical. Thoracotomy was performed on 22 patients. Thirteen of them underwent lobectomy or pnemonectomy. Of the 40 patients, 33 received HN_2 therapy: 12, a single dose; and 21, three or four doses. Thirty-four of the 40 patients had multiple admissions. The average stay of each patient in the hospital was 26.5 days. Six patients stayed in the hospital an average of less than ten days. It was estimated that for each patient the cost of hospitalization and treatment was approximately $1,675.00 and the time lost from work about 60 days. Since almost 65 per cent of patients with carcinoma of the lung fail to survive one year, these patients spend approximately one-third of their remaining lives in the hospital. These figures emphasize the necessity for treating these patients as rapidly and as economically as possible.

During the same eighteen-month period referred to above, 47 patients with lung cancer were seen in the Department of Radiotherapy.[15] Some of them were ambulatory and others were among the hospitalized group. All were treated by means of the 2 million volt Van de Graaff x-ray machine. Some completed a full course of treatment; in other cases, the course of treatment was short or interrupted. The symptoms and clinical findings, in order of frequency, and the number who received some degree of palliation are shown in table 1.

A high percentage of patients will be found to have brain metastasis at the time of diagnosis of carcinoma of the lung. For example, at a recent conference on lung cancer the panel voted the electroencephalogram the third most important laboratory procedure that should precede specific treatment. The laboratory tests in order of importance were voted as follows: (1) Chest film, (2) complete blood count, and (3) electroencephalogram. Symptoms and clinical findings in order of importance were voted as follows: (1) Weight loss, (2) pain in the chest, (3) hemoptysis with cough, (4) headache, and (5) nocturnal bone pain.

TABLE 1

Palliation of Symptoms and Clinical Findings After Radiation Therapy in 47 Cases of Carcinoma of the Lung

Symptoms of clinical findings	Number of cases in which present before therapy	Number of cases in which palliation after therapy
Cough	45	40
Chest pain	31	26
Hemoptysis	26	25
Distant bone pain	18	12
Superior vena caval syndrome	12	12
Distant nodes	9	8
Positive electro-encephalogram	3	0

A review of five case histories reveals a number of conditions that, in retrospect, should have been obvious and diagnostic. All five patients had complained of morning cough and afternoon fatigue and had had unexplained "small shadows" on chest x-rays taken by their local physicians. Each of these patients

TABLE 2

Objective and Result a Year Later of Radiation Therapy for Carcinoma

Site	Number treated	Objective		Living		Dead with disease
		Cure	Palliation	With disease	No evidence of disease	
Mouth	31	10	21	12	7	12
Pharynx	5	3	2	1	2	2
Lung	34	0	34	6	2	26
Esophagus	6	0	6	1	0	5
Breast	13	0	13	5	1	7
Ovary	12	1	11	4	2	6
Uterus	9	4	5	1	2	6
Cervix	33	18	15	11	10	12

had been observed for six to eight months and treated symptomatically. Each of them developed an inoperable, incurable lesion. Time, therefore, is the most important single factor in the successful treatment of carcinoma of the lung.

Of the 47 patients referred to above,[15] all of whom were treated with 2 million electron volt x-rays (MEV), 34 were treated more than one year before this analysis was made. Of the latter number, 8 had survived for 18 months. The average survival time was 10 months. Cancer of the lung comprised 8.7 per cent of cancer of all types treated in our institution during this eighteen-month period. Since the disease had advanced to different stages in the various patients at the time treatment was begun, it is difficult to accurately analyze the survival of patients after specialized treatment. In table 2 are shown the objective and the result, one year later, of treatment of patients who had carcinoma in various sites, in this department.

Definitive Therapy

Patients accepted for definitive therapy should be carefully examined and all of the past findings and operative procedures should be carefully reviewed. Treatment must be individualized. My colleagues and I[16] feel that best results will be obtained if therapy is clearly outlined and the dose schedule calculated, using the patient's measurements and a cross-sectional diagnosis at the tumor level. A chest film, using the Van de Graaff 2 MEV beam is made. This type of film often outlines the tumor more precisely than does regular film. The 2 MEV x-rays from a small focal spot have very little penumbra. Thus, the beam is easy to direct, control and shape to fit the anatomic part to be treated. The beam also gives excellent definition and a high quality film. The films are used in therapy to assure the passage of the beam through the correct location to surround the tumor. Positional films are exposed with the patient in treatment position.

Methods Outlined

It seems proper at this point to outline in some detail the methods which we use. In figure 1 is shown a patient in position for therapy. The outline on the chest represents the port through which the x-ray beam will pass to treat all of the irregular tumor area and mediastinal nodes. The outlines of the port may be shifted to conform with the tumor area, and the satisfactory port is inked in with Castallanio Skin Paint. The marks are repainted from time to time during the course of treatment. Anterior and posterior or co-planar ports are lined up to coincide by using lead wires to outline each for a positional film study. Note lead wires shown in the figure. The light beam is coincident with the x-ray beam. Therefore, the lead blocks that are used to shape the light beam to coincide with the port outline will shape the x-ray beam.

The film under the patient is exposed with the shaped x-ray beam (figure 2). Note the very sharp edges, without pneumbrae, after passing through the chest (24 cm. diameter). The irregular field encompasses the tumor area, nodes and invasion sites. This radiograph was made with the therapy beam of 2 MEV. Such fine definition can be obtained from machine-produced x-rays from a very small focal spot. Co 60 rays come from very large sources (2 to 3 cm. diameter). Positional films are necessary to validify the correct therapy port.

Lead wires are laid over a port that is selected (figure 3). A large chest film shows the tumor area surrounded by the lead wire shadows. The port outline may then be changed to properly fit the area for treatment. As stated above, the port is marked with Castallanio paint of frequent intervals during the schedule, to insure reduplication of position.

In figure 4 is shown an autograph of the patient shown in figure 3. The tumor area as it appeared during the third week of treatment is visible. The shaped beam covers the left hilum tumor and mediastinum. The objective aim of the treatment schedule was 5500 "r" maximum T.D. in five weeks. This was accomplished without discomfort or skin reaction.

Figure 5 is a post-therapy film of the patient shown in figures 3 and 4. Note the reduction in the size of the tumor area. Twenty-six months after treatment, this patient is still living.



Figure 1
Arrows, from top down, point to:
End of x-ray machine
Lead beam shaping blocks
Plexiglass table—to support lead blocks
Light source—coincident with x-ray beam

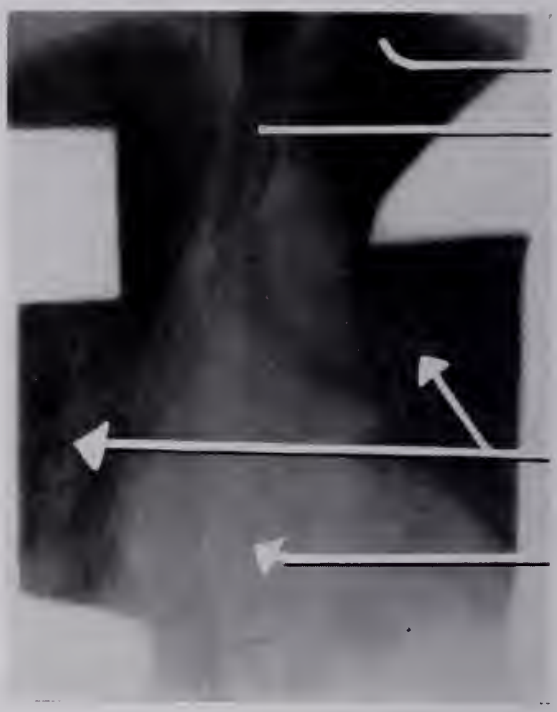


Figure 2
Arrows, from top down, point to:
Apical tumor
Trachea
Tumor area
Mediastinal nodes



Figure 3
Arrows, from top down, point to:
lead wire, lead wire and tumor hilum.

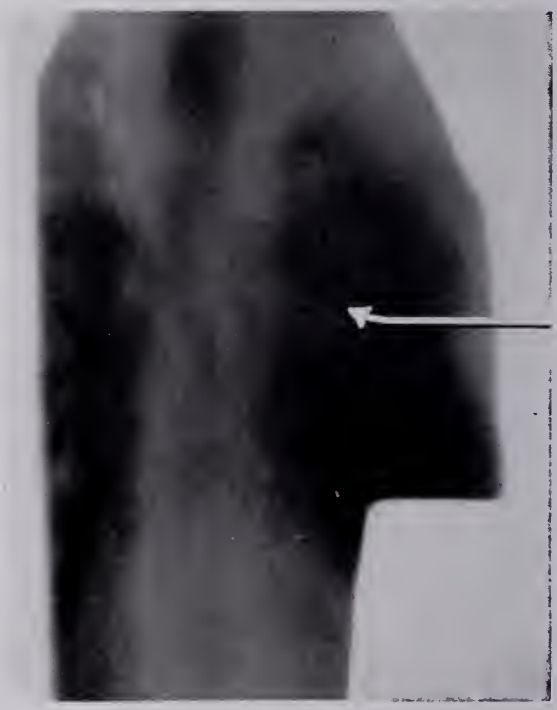


Figure 4
Arrow designates tumor area during third week of treatment.



Figure 5
Arrow denotes tumor area controlled.



Figure 6
Figures 6, 7-A and 7-B are explained in the text at left.

As shown in figure 6, complicated areas such as hilar nodes, mediastinal nodes and supraclavicular nodes may be incorporated into a single field and the geographic distribution of the beam coverage verified by a positional film. X-ray therapy through any vital area never should be attempted without a positional film study.

The 2 MEV x-ray film is often more diagnostic than regular 100 KV films (figure 7). The pathology is obliterated in the regular film shown in figure 7 (a) by atelectasis and pneumonitis. In figure 7 (b) the film locates and defines the abscess and intralobar empyema. Note the absence of bone shadows. Tumors and other pathology are outlined by contrast with the air-filled lung.

In the past, conventional x-ray therapy could not deliver adequate tumor dose to the mediastinum and hilum without causing undue skin reaction (figure 8). The use of several ports aimed at the tumor area might yield an acceptable dose and give palliation, but fibrosis of the lung where the multiple beams crossed could be ex-



Figure 7-A



Figure 7-B

wherever there is inflammation, swelling, pain

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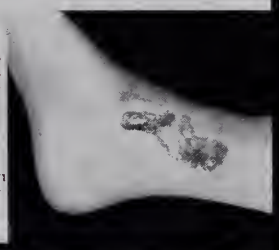




FORCE INJURY

severe bruises ... swelling ... cleared by fifth day[2]





VARICOSE ULCER

'15 years duration ... resolved with VARIDASE[1]





INFLAMMATORY DERMATOSIS

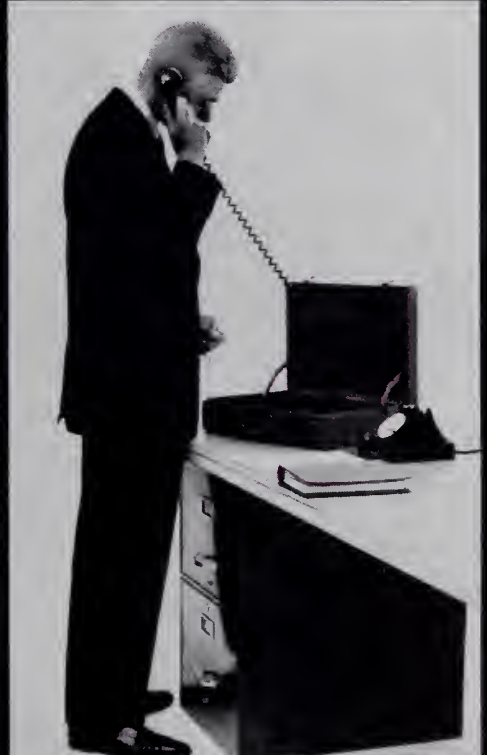
rapidly spreading rhus dermatitis healed within a week[1]





INFECTED LACERATION

marked reversal in 3 days... returned to school... closure advanced[1]





THROMBOPHLEBITIS

back on his feet in a week after recurrent episode[1]





REFRACTORY CELLULITIS

normal routine resumed after 4 days of VARIDASE[1]

pected (figure 9). The use of supervoltage in the energy range of 2 MEV will give adequate tumor dose, without skin damage, and without irradiating too much of the lung tissue (figure 10). Usually co-planar ports are used.

During the past twenty years radiation therapy has been handicapped because of the limitations of the high energy x-rays energy and the lack of interest in this specialty and the small number of individuals devoting full time to therapy problems. For example, in 1949 a survey revealed that there were only 38 full-time radiotherapists in the United States. Fortunately, the number has increased to approximately 96 in 1959. The busy radiologist finds it difficult to do diagnostic work and, in addition, adequately examine and manage the therapy of patients. Progress also has been hindered because small hospitals and departments do not have space to devote to or money to invest in supervoltage equipment that is necessary to provide adequate therapy. The cobalt machine does not provide the final answer to roentgen-ray therapy, because the usual machine is small and requires close treatment distance, which cancels the advantage of the high energy depth dose. The large CO^{60} machine has a source of high activity, requires a large space and expensive shielding, and its use requires a large portion of the radiologist's time. If adequate facilities are not available, the radiologist and the hospital administration should feel morally obligated to send patients to areas that have available supervoltage machines and specialized service.

Evidently chemotherapy will increase in use and value as we improve our conception of malignant disease and its behavior and control. In my opinion, it would be instructive and perhaps informative to treat a series of "operable" lung cancers with controlled supervoltage x-rays on the diagnostic strength of a chest film, a Papanicolaou smear and possibly an exploratory thoracotomy.

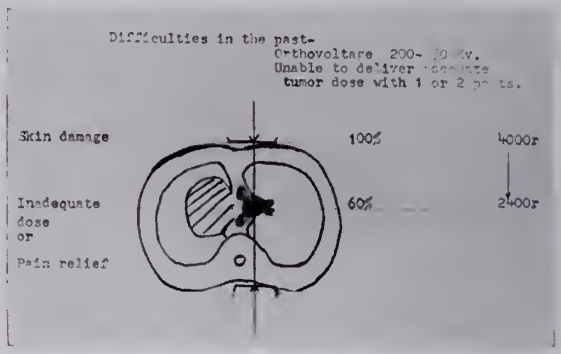


Figure 8

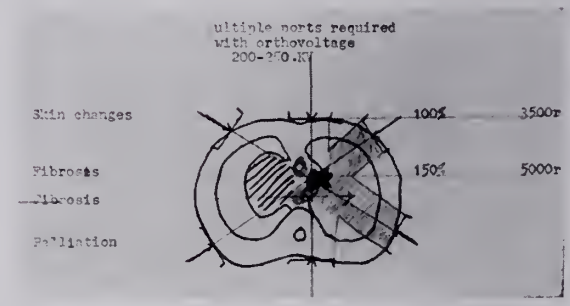


Figure 9

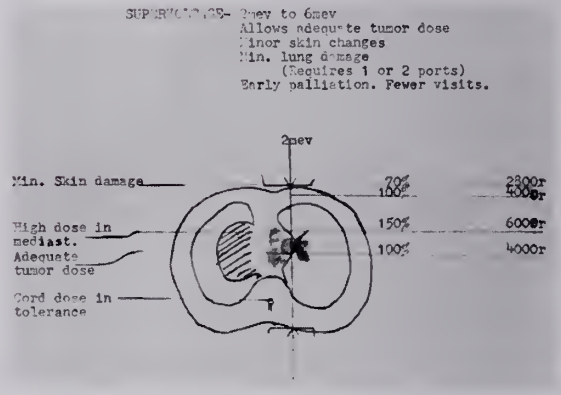


Figure 10

Summary

Nitrogen mustard is the most useful of the chemotherapeutic agents available at this time for the treatment of carcinoma of the lung. It is of greatest value, regardless of the extent of the procedure performed or disease present, when administered intravenously in the postoperative period. Dilute solutions of this agent may be used to wash out the pleural cavity. The intravenous administration of HN_2 has proved especially effective in the treatment of the superior vena caval syndrome. Chemotherapy is also of value in the treatment of carcinoma of the lung when given as a preradiation agent. It may reduce the extent of single or multiple lesions and sensitize the tumor for x-ray therapy. Adequate HN_2 therapy usually is reflected in temporary depression of the bone marrow. Com-

plete control of a tumor by chemotherapy alone never has been observed.

Radiation therapy is of value, particularly in obtaining palliation in the treatment of bronchogenic carcinoma. Supervoltage x-rays achieve palliation more easily and simply than orthovoltage x-rays. A device for shaping the beam to fit the geographic area to be treated is necessary. The possible value of supervoltage x-ray therapy for "operable" carcinoma of the lung should be tested.

Since, for the most part, curable carcinomatous lesions of the lung are those that have not progressed past the subclinical stage, methods of detecting and diagnosing carcinoma of the lung while it is still in that stage should be intensively investigated and sought.

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THE SURGICAL CONSCIENCE

Conscience in surgery means a strong sense of right and wrong, a willingness to help others, a feeling of compassion for the unfortunate, self-discipline, and a strong faith in the sanctity of God and man. It can be conditioned by education and experience. It depends not only on the surgeon's individual moral fiber and religious concepts, but also on his heritage of philosophical doctrines, his scientific and factual knowledge, and his judgment. It determines his conduct in many situations, such as the current difficulty with hospital-acquired infections, where temporary individual gains from the misuse of antibiotics may result in protracted trouble to a community. It compels the surgeon at times to resist popular demands and to have the moral courage to protest. It requires him to rise above the selfishness of small professional groups and to devote himself to the individual patient with gentleness, compassion, firmness, and resolution. Many of the current problems concerning the care of the sick are complicated, not solved, by rigid regulations and dictatorial authority. Their solution depends, rather, on a rebirth of the surgical conscience.

—W. A. Altemeier, M.D., AMA Arch. Surg., Aug. 1959.

LOUISVILLE GENERAL HOSPITAL*

Postpartum Eclampsia

History

M. L. S., a 16-year-old negro primigravida, was first seen in the prenatal clinic of the Louisville General Hospital on December 24, 1958. Her menstrual history was somewhat confused, but her expected date of confinement was estimated to fall in March, 1959. The physical findings at the initial examination were within normal limits, except for the observation that the abdomen was larger than seemed consistent with the estimated duration of gestation; hydramnios was suspected. The public arch seemed narrow, but the diagonal conjugate was clinically adequate. At the initial visit, the blood pressure was 115/60, and there was no albuminuria or edema. The fetal heartbeat was readily heard in the left lower quadrant. The impression was that of a normal intrauterine pregnancy in a primigravida.

At three subsequent prenatal visits, no abnormalities were noted. On February 18, 1959, the blood pressure was 136/66 and there was 1 plus pitting edema. The abdomen continued to appear larger than expected for the period of gestation. The patient had no complaints.

On March 4, 1959, the patient reported to the hospital an hour after spontaneous rupture of the membranes had occurred at home. She was having a few irregular uterine contractions.

Physical Findings

Upon admission, the blood pressure was 130/70, pulse 104, respirations 20. There was a grade 1 percordial systolic murmur. The abdomen was enlarged markedly, and two fetal heartbeats were heard, one counted at 152 beats per minute in the left upper quadrant and the other at 144 beats per minute in the right lower quadrant. On vaginal examination, the presenting twin was at station—2; the cervix was 4 cm. dilated. The clinical suspicion of twins was confirmed by an x-ray. Roentgen pelvimetric measurements were within normal limits. The remainder of the general physical examination was not remarkable.

Treatment and Hospital Course

Labor progressed uneventfully, and after seven hours of first stage labor and one hour and fifty-eight minutes of second stage labor the patient was delivered, under cyclopropane anesthesia, of twins weighing respectively five pounds, three and one-half ounces, and five pounds, eight and one-half ounces. The first twin was delivered by partial breech extraction from right sacro-anterior position; the second was spontaneously delivered from LOP. A left mesolateral episiotomy was performed. Manual removal of the placenta was done immediately postpartum, and two separate placentas with membranes characteristic of maternal twins were removed. Mother and twins left the delivery room in good condition.

One hour postpartum, the patient's blood pressure was 160/95; the pulse was 64. A few clots were expressed from the uterus; gentle massage then produced good uterine contraction. Because of the elevation of blood pressure, one fourth grain of morphine was administered intramuscularly. There was a prompt drop of the blood pressure to 140/84, and the patient seemed to be in reasonably good condition. However, two hours later, at 11 p.m.,

* *Patient Protocol #93569.*

the patient suddenly exhibited a tonic and clonic convulsion which was followed by a deep coma. Twenty cubic centimeters of fifty per cent magnesium sulfate were administered intramuscularly together with 1/4 grain of morphine. Examination of the eye grounds just before the administration of this medication showed there to be segmental vasospasm of moderate degree. Shortly after the administration of this medication, the blood pressure, which had risen to 210/110 at the time of the convulsion, dropped to 100/68. The patient exhibited stertorous breathing, and continued to be out of contact with her environment. There was no further rise in the blood pressure, however, and the next morning it was stable at 120/80.

Approximately twelve hours following the convulsive seizure, the patient was rational and asking about her babies. At this time, the urine showed 2 plus albuminuria and was loaded with erythrocytes. The uric acid was 3.9 milligrams per cent. Non-protein nitrogen was 17 milligrams per cent. During the next three days, the blood pressure remained stable and the urinary output was good. On March 8, 1959, the patient was well enough to go home. At the six weeks postpartum examination on April 24, 1959, the blood pressure was 100/80, and the patient appeared in excellent general condition.

Discussion

Douglas M. Hayes, M.D., Professor and Chairman, Department of Obstretics and Gynecology, University of Louisville School of Medicine.

The patient described illustrated the typical clinical picture of postpartum eclampsia. This diagnosis is mandatory whenever a patient demonstrates convulsive seizures followed by coma within twenty-four hours of delivery, provided that other causes of convulsions cannot be demonstrated. Since eclampsia is simply one type of toxemia of pregnancy, the other clinical criteria for the diagnosis of toxemia must also be met. These criteria are two or more of the triad of hypertension, albuminuria and edema.

The patient described presented no evidence of toxemia of pregnancy prior to delivery, and represents one of the less usual types of severe toxemia. Approximately one-half of all cases of convulsive toxemia of pregnancy are observed antepartum, occurring some time during the third trimester but before the onset of labor. One fourth of the patients exhibit their convulsive phase during labor and the remainder develop it postpartum. It is interesting to note that the patient under discussion had a twin pregnancy, a condition which is associated with a higher incidence of toxemia of pregnancy than is the case in the population at large, and yet did not demonstrate the syndrome until after delivery of the twins.

Diagnostically helpful in the differentiation of eclamptiform from other types of convulsions is the characteristic coma, usually of several hours' duration or longer, which follows the eclamptic convulsion, but is not ordinarily present in many other types of convulsions, notably epileptiform seizures. If, following a convulsion in the third trimester of pregnancy, a patient is alert and reactive within minutes of the seizure, eclampsia is almost certainly ruled out.

Although, in general, eclampsia can be considered a preventable complication of pregnancy, since most cases are heralded at the outset by clinical signs of toxemia of pregnancy which can be elicited early and eliminated by a relatively simple treatment, an occasional patient will develop a fulminant toxemia without prior warning. This is illustrated by the patient in question, who showed no signs of toxemia until just before the convulsion occurred. Once a patient has had an eclamptiform convulsion, her prognosis worsens greatly; it has been estimated that the maternal mortality rate in eclampsia may be as high as between 10 and 15 per cent. Furthermore, the number of convulsions appears to have direct bearing on the outcome, so that the principal aim of the treatment of eclamptic patients is to cut down the total number of convulsions to as low a figure as possible.

The treatment of the eclamptic patient is empiric, and is aimed principally at the control of the manifestations of the disease; the obstetric status of the patient is ignored. Since the convulsions are extremely dramatic events, there is a tendency for over-treatment to be the rule, and this may be just as harmful as under-treatment. Although controversy continues to rage as to the best means of treating eclamptic patients, certain principles have now been well established. The first of these is that when the convulsion occurs antepartum, immediate delivery

by whatever means is dangerous and will result in an increase in the maternal mortality rate.

Eclampsia, therefore, represents a contraindication to the performance of cesarean section or to the immediate induction of labor. The actual method of control of the convulsions varies greatly in different areas of the world. Heavy doses of sedative drugs, principally morphine, chloral hydrate, magnesium sulfate, barbiturates and bromides, have been recommended by various investigators. Of these, the barbiturates appear least desirable, as the eclamptic patient is extremely susceptible to suddenly developing pulmonary edema resulting from cardiac failure; for this reason the use of barbiturates is to be avoided.

Morphine appears to be a useful drug in the treatment of this disease, but it must be administered in sufficient dosage so that the convulsions are well controlled. This sometimes necessitates the administration of very large doses of morphine, but experience with this method has demonstrated that eclamptic patients are extremely tolerant to large doses of morphine, and that as long as the respiratory rate is maintained in the neighborhood of 12 per minute, control of the convulsions is usually effective. External stimuli must be minimized in the vicinity of the eclamptic patient, as sometimes very minor disturbances may initiate another convulsion or series of convulsions.

A useful adjunct in the management of convulsions is the intravenous or intramuscular injection of magnesium sulfate; this drug has a strong sedative effect on the central nervous system, relieves edema and promotes diuresis.

In the case of postpartum eclampsia, the heavy sedative routine should be maintained for at least 24 hours after the convulsion. If the seizures occur antepartum, active attempts at induction of labor should be delayed until no convulsion has occurred for three days. In the case in point, recovery was prompt, and no residual damage was observed at the six weeks' postpartum checkup. Some authors have reported that certain patients with severe toxemia of pregnancy exhibit permanent residual damage manifested as essential hypertension following the pregnancy in which the toxemia occurred. Such patients are occasionally seen, and furnish evidence of an intimate but poorly understood relationship between essential hypertension and certain forms of toxemia of pregnancy.

SPECIAL ARTICLES

Let's Not Be Sold Out*

ROBERT W. ROBERTSON, M.D.

1958-1959 KSMA President

Paducah, Ky.

BACK in 1945, when I walked up the gangplank to board a ship to return to the United States after a three-year stay overseas and realized this would probably be my last glimpse of Italy, perhaps to lose contact with some of my close associates—there was a twang of remorse in my heart, even though I was glad to be on my way home.

Today, there is both gladness and sadness in my heart. It is relaxing to know my tenure is nearly over and I will have more time to devote to both my practice and my family.

On the other side of the ledger, there is a void in my heart for I will miss the wonderful times I have had traveling around our state to various meetings, the good comradeship of my colleagues and the opportunity of getting a better insight into the problems confronting medicine.

A Presidential Thank You

So you see, my situation now is comparable to that of some fourteen years ago. However, I didn't thank Uncle Sam for his honor, but I want to thank you for yours—for your faith in selecting me president, for your many splendid courtesies extended not only to me but also to my family, and finally for your excellent cooperation in working on Association matters. You have been wonderful to me and it is appreciated. My wife and I will look forward to having you as our guests if you are ever in Paducah.

Well, I mentioned earlier something of the problems confronting medicine. What are these problems? There are many; you know that. So in the next few minutes, I have decided to take only one of our problems and expound a bit on it. I have chosen Forand-type legislation, not so much because it is the Forand Bill, but because it encompasses far more than just being another bill in the Congressional hopper.

Status of Forand Bill

First, let us consider the present status of the Forand Bill which is known as HR-4700. Congressman Aime J. Forand, a Democrat from Rhode Island, introduced this legislation in the 85th Congress. It did not get out of committee. Again, he introduced it into the 86th session of Congress, where again it was referred to the powerful House Ways and Means Committee on which Mr. Forand himself is the second-ranking member.

Hearings were held on the Forand Bill the week of July 14. One of our own Kentucky physicians, Carl Fortune, M.D., of Lexington, testified against the Bill along with a number of other State Medical Associations, the AMA, and other medical groups. When the hearings closed, there was no action taken by the Committee to bring the Bill out on the floor of the House. It is presumed that it will not come out of committee until 1960. However, we should remember that it can be brought out at any time, since the hearings have been held.

We find ourselves in a position of having to defend this sort of legislation when the philosophical and social climate is increasingly un-

*President's address presented at the 1959 KSMA Annual Meeting in Louisville on September 22.

favorable. While there are still many people who are planning for their old age, it is apparent that there is a growing number of our population that has no interest in planning for its future through any of the accepted techniques or methods. This may be because that during the depression the philosophy was widely spread that people should spend as fast as they might earn or borrow or otherwise acquire money. You might say it is thought to be an economic crime to save. Certainly it is felt that Government will somehow provide needed medical care.

Another philosophy is being actively promoted which leads people to believe that Government-financed medical care will give them more and better care for less money. It is not necessary for us to refute this fallacious argument.

Then again, we have still a third point of view to combat. That is, we can have Government financing of medical care without Government control of medical care. Now certainly Congress has made its mistakes, but you and I both know that we will never have the opportunity to criticize Congress for taking the people's tax funds to set up a system of medical care without keeping control of the system.

Lack of Understanding Noted

Some members of our profession feel that our position has been somewhat weakened by the fact that we in medicine seek to concentrate on the improvement of our medical care and have not given sufficient thought to other aspects, including adequate distribution of medical care. The proponents of Government spending, on the other hand, do not understand the essentials of good medical care. They tend to take that for granted and to assume that the Government can effect a better distribution and management of better medical care.

Proponents of Forand-type legislation are not impressed by the fact that physicians' fees for services rendered have not risen anything like as rapidly in the last two decades as charges for other groups rendering service to the public. For instance, during that time, costs of such essentials as food and clothing have more than doubled, while the average general practitioner's fee has risen approximately 73 per cent. Other types of medical service have risen a little more or a little less.

The advocates of Government control are equally unimpressed with the fact that the amount of the medical-care dollar that goes to the physician is decreasing, while that which goes to hospitals, drugs, etc., has been increasing. No consideration is given to the fact that although newer drugs and newer surgical techniques are more expensive they, at the same time, cause people to get well much quicker, and the cost in the end is less.

According to our statisticians, by 1965 there will be an increase of approximately 38 per cent in our population under 21 years of age. By 1965, there will be an approximate increase of 35 per cent of our population of 65 years and over. However, in the age group between 21 and 65, we may by 1965 expect an increase of only 9 per cent. Immediately, it becomes apparent that by 1965 we may look forward to increased taxes to take care of our school-age population, and perhaps strong pressure to increase taxes to take care of our aged. We will have to obtain these taxes from a relatively smaller group of what is normally thought of as the main tax-producing group—21 to 65.

Members Urged to Read Bill

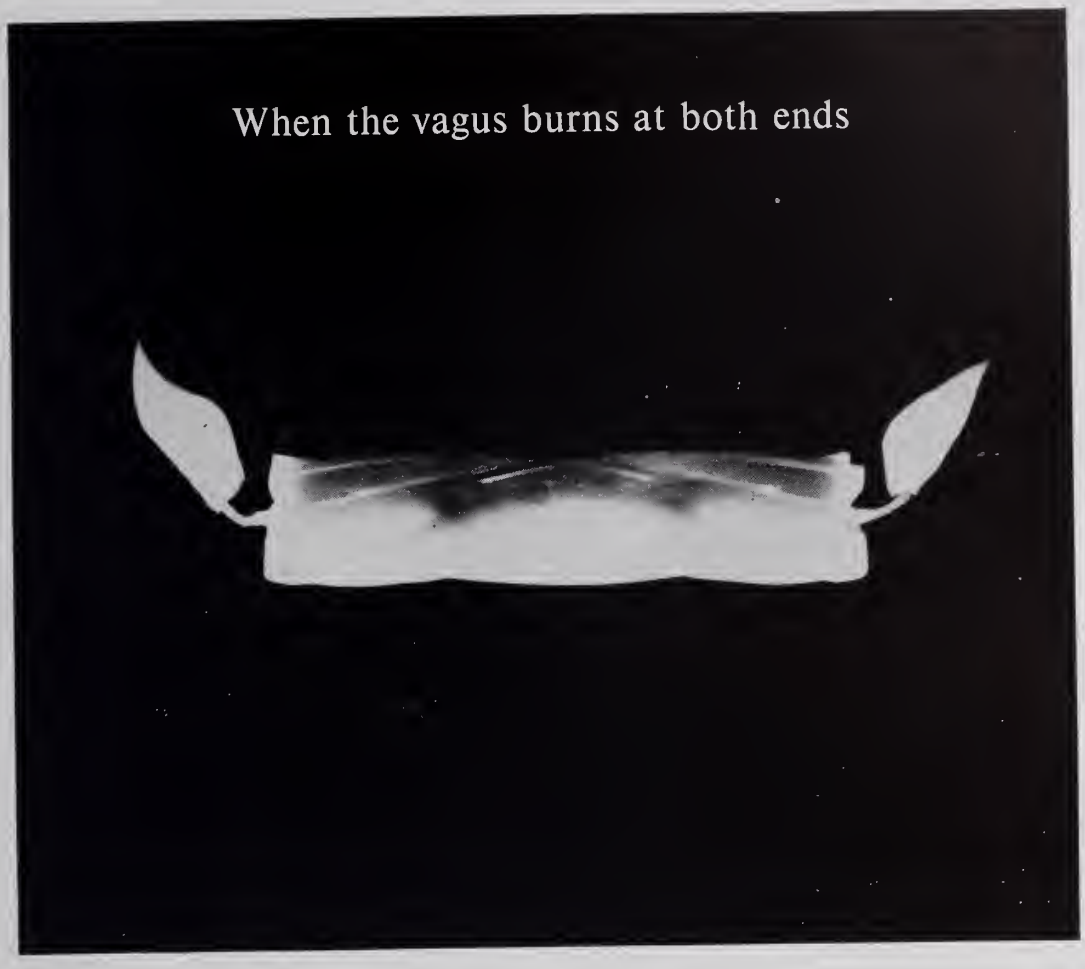
Now, let us consider the Bill itself. Just what are we resisting? Do you know? Have you read the Bill? If you have not read it and do not have a copy, let me make a very important suggestion at this point. Write your Congressman at your very earliest convenience and ask him for a copy of this bill. It is known as the Forand Bill and its number is HR-4700. Write your Congressman for a copy tonight or as soon as you get home.

Then, after you read the Bill, be sure and let your Congressman know how you feel about it. He'll be coming home in a few days—go to see him this fall.

Until you have an opportunity to read it, let's touch briefly on some of the reasons why we, in medicine, are seeking the defeat of the Forand Bill.

Reasons for Resisting Bill

First of all, the cost would be exorbitant. While the proponents of the Bill sugar the idea by telling us that the withholding tax increase would be very gentle at first and would gradually increase, experience in other give-away programs and in schemes of this type that have been promoted abroad show these estimates to be inadequate.



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Secondly, it would give free hospital, medical, and other services to a vast group of people including bank presidents, corporation executives, and highly-paid business leaders along with a host of other people—when these groups are quite able to pay for it themselves.

Thirdly, the effects of the Bill in operation would be to greatly reduce the usefulness of our "Blue Plans" and the insurance industry, and thus take another big step in discouraging private enterprise.

We could continue on and on, but there is one other reason why we are forced to resist this legislation, and that is that it takes the social security administration out of the field which its founders have intended and introduces an entirely new concept. That is of providing services. This could not only be a long step in the direction of socializing medicine but also in promoting the socializaton of other professions and types of businesses.

Conference on Aged Supported

Congressman Fogarty, who comes from the same state that Congressman Forand does, last year introduced a resolution in Congress, calling for a White House Conference on the Aged for 1961. The AMA supported this resolution, feeling that more formation is needed on the problem. This was voted without difficulty and funds are being made available through the various states and plans are going ahead for the Conference. Now the purpose of the Conference will be to study the situation to find out if there really is as much of a problem in the health and welfare of our senior citizens as some would have us believe, and possibly to make recommendations.

As a result, here in Kentucky the Governor's Commission has already been set up. This Association is represented, several of our members are on the Commission, and it has already started work. Money has been made available to the Commission to set up a staff. Information on the aged will be assembled and sent to the White House Conference in 1961.

President Eisenhower told the American Medical Association at Atlantic City this past June that, "Impressed as we are by the progress in the medical sciences, including miracle drugs, miracle operations, and break-throughs in eliminating heretofore incurable diseases, we sometimes forget that this progress deposits new problems on our doorstep."

The President is right. Due to the advances in medical sciences brought about by the teamwork of the health profession in the past fifty years, man's life expectancy has increased about thirty years. We must work as effectively in solving the problem of the aged as we did in helping to create it.

From the foregoing, gentlemen, we believe that you will agree that solving the problem of the health and welfare of our senior citizens is felt by many of our own KSMA leaders as well as the leadership of the American Medical Association to be the most important problem facing medicine today in general, and that the defeat of the Forand-type legislation is the most important single problem.

The successful resistance of Forand-type legislation must take two courses and they must be pursued simultaneously and vigorously. First we must defeat the Bill. There can be no "ifs and ands" about it, gentlemen; the Bill must be defeated. And secondly, we must find a way within the framework of the private practice of medicine to solve the problem, through private enterprise. We believe that you will agree that it is a problem to be solved, primarily, at the local level. Bitter experience has taught us that only a small per cent of the tax dollar that goes to Washington returns to the local community.

Job Must Be Done At Home

The job will have to be done at the grassroots level. It will have to be done in the individual districts of the individual Congressman. We can't expect the AMA to win this fight for us; neither can we expect our own Legislative Committee to write letters to Washington and hope for effective results. This job must be done by us as individuals—at home.

Perhaps you will be interested in knowing Congressman Walter Judd's idea—he is a physician. Doctor Judd said, "How can doctors influence their Government's action on matters affecting medical service? By all odds, the most potent weapon is NOT resolutions, and floods of letters and telegrams. It is personal explanation of the issues to the Representatives or Senators by the doctors themselves." Congressman Judd also suggests that members of the medical profession may have their greatest influence on the public by working along with other patriotic citizens in electing people to Congress who will work for better Government.

(Continued on Page 1414)

EDITORIALS

Medical Care In Alaska

ON a recent tour of Alaska we thought it might be profitable to learn something first hand regarding medical care in that state. To secure information we made inquiry wherever possible, visited the State Director of Health at Juneau and talked with a number of physicians, visited five hospitals—three civilian and two under U. S. Public Health Service.

The population of Alaska is about 210,000. There are 18 general hospitals now in operation with bed capacity of 527 and one 16-bed tuberculosis hospital for non-native patients. Two general hospitals with bed capacity of 29 are not now in use. There are seven U. S. Public Health Hospitals with bed capacity of 943 serving only the native population—Indians, Aleuts and Eskimos. There are two Fish and Wildlife Hospitals on the Pribilof Islands staffed by U.S.P.H.S. with a total of 14 beds. Some beds in the Alaska Native Health Service hospitals are devoted to the care of tuberculosis, but there is now less demand for these and they have been converted to a large extent to general medical care.

Care of Mental Patients

Contract arrangements are made for the short time care of acute mental patients in the general hospitals and the Alaska Native Health Service Hospitals. Long term mental patients are cared for at a 450-bed private hospital at Portland, Oregon, on a contract basis with the state. Plans are being drawn for a 225-bed acute mental hospital at Anchorage which is planned for 400 beds in the future. Plans are being made for the care of 200 patients by converting an existing facility at Valdez, Alaska.

The several Army and Air Force installations are not included in the population stated. Since they have their own hospitals and professional personnel, no account is made here of the number of hospitals or total number of beds devoted to military persons and dependents.

Hospitals Strategically Located

The population of 210,000 is, of course, scattered over a very wide area but so are the hospitals placed at what would appear to be strategic points and they vary in size from 3 beds to 79 beds each, generally in proportion to the size of the community served. Wherever we inquired we were told the hospitals were not overcrowded and ample beds were available to serve the community properly, except in Anchorage, the greatest center of population. Forty-five thousand people live in this city and their surrounding trade area is said to have a population of 100,000 or more. There is one general hospital with 74 beds. They are overcrowded, but subscriptions are now under way to build a new hospital there with 125-bed capacity. Plans call for construction to begin in 1960. The Anchorage Medical Center is also located there—a U.S. Public Health Facility with 400 beds. Plans are less complete for expansion of hospital capacity at Fairbanks, population 15,000, with now a 70-bed hospital.

112 Practicing Physicians Listed

The latest AMA directory lists 112 practicing physicians in Alaska. This figure is perhaps deceptive because of the number who have gone there during the past two years. Distribution is perhaps about the same problem there as here; however, with hospitals widely scattered, there has been sufficient incentive for physicians to locate in smaller towns rather evenly distributed over the area. Anchorage has 48 physicians, Fairbanks 14, Juneau 9 (population 9,000), Ketchikan 9

(population 12,000). In these larger cities the various medical and surgical specialities are represented, and some of the men are Board Certified. Nowhere were we told that there was an urgent need for more physicians to care for the people's needs properly, except in one instance where one of the smaller hospitals is temporarily without a physician.

Dr. Harry V. Gibson was Commissioner of Health when Alaska was a territory and now carries the title of Director of Health. He described for us the role of the U. S. Public Health Service to the native population. It would appear impossible to extend vaccination, health education and maternal care to such widely scattered and thinly populated areas as are represented in the small native villages, but apparently this is being very successfully accomplished.

Travel By Plane Or Boat

Travel is mostly by plane or boat and often strenuous and time consuming but Doctor Gibson or his staff has fairly good communication with the most remote places. He told me that most of the natives come into hospitals for delivery of their babies often aided by "bush pilots" without whose operations many areas would indeed remain remote. There is close cooperation of his state health department with the U.S. Public Health Service covering the entire state.

Miss Helen Hartigan, R.N., Chief of Nursing Service, gave us a pamphlet which is used for health and maternal education among the native people. She pointed out that this leaflet was prepared largely after the plan of that used in our own frontier nursing service in Kentucky—simplified with drawings and sketches that can be easily understood. Incidentally, Kentucky seems otherwise to be well known in Alaska. Many menus carry "Kentucky Fried Chicken," grass on the lawns is generally a mixture with Bluegrass, and our local brands of beverage are found everywhere.

Miss Betty Malay, R.N., is in charge of Public Health Nursing at Point Barrow, the farthest-north community in the state with an Eskimo population of about 1,500. Description of her work there and in the remote native villages along the Arctic Ocean and inland was inspiring. Never have we had a higher regard and appreciation for our public health services than in connection with these isolated native people of Alaska. The children in the most inaccessible villages receive immunizations almost as regularly and faithfully as in our own cities, and epidemics of disease are reported and attended with promptness and thoroughness one would think impossible.

Hospitals In North, South

In 1953, there was built in Anchorage by U. S. Public Health Service a magnificient 400-bed hospital which is devoted to the care of native population throughout the northern portion of the state and the Aleutian Islands. A similar hospital at Sitka performs the same service for the southern portions of the state.

Dr. Kasumi Kasuga, Japanese native of California, graduate of the University of California School of Medicine, Veteran of World War II, and since the war in the U. S. Public Health Service, is director of the hospital at Anchorage. He has a staff of 20 physicians covering most of the medical and surgical specialities and uses consultants freely from among the practicing physicians of Anchorage. Of his 400 beds, 90 are now devoted to the care of tuberculosis and 310 for general medical service, a small obstetrical service cares for 15-20 patients per month. On the day we visited there was an 82% occupancy of the beds which he said is about average.

Medical Care On High Plane

Our visit to the new state of Alaska left us with the general impression that medical care there is on a very high plane, on a par perhaps with that found in most of our other states. The men in private practice seem generally well prepared for their responsibilities. There seemed nowhere an urgent demand for more physicians except as is occasioned by the normal and rapid growth of some of the cities. Hospital facilities would appear to be as adequate as in the other states. The U.S. Public Health Service is performing magnificently against what would appear to us almost insurmountable odds of distances, climate and language barriers. Of this service particularly we should be proud.

Sam A. Overstreet, M.D.

ORGANIZATION SECTION

Dr. Elliott of Lexington Is New KSMA President-Elect

Richard G. Elliott, M.D., Lexington, was named president-elect of the Kentucky State Medical Association by unanimous vote of the House of Delegates at the Wednesday evening, September 23, meeting of its 1959 session.



Dr. Elliott

A native of Lexington, Doctor Elliott received his A. B. degree from the University of Kentucky in 1928 and his M. D. degree from Vanderbilt University School of Medicine in 1932. He started practicing medicine in Lexington in 1935, after completing his internship at Charity Hospital in New Orleans and residency training at children's hospitals in Cincinnati and Philadelphia.

Doctor Elliott, a member of the American Academy of Pediatrics, was certified by the American Board of Pediatrics in 1937. He is also a member of the Southern Medical Association and a past president of the Fayette County Medical Society. During World War II he served four years with the U. S. Army and he is a Colonel in the Medical Corps USAR, retired.

Active in KSMA, he is councilor of the Tenth District and has served as chairman of the Association's Committee on Public Information and Service and the Senior Day Committee.

Elected vice presidents at the meeting were: David M. Cox, M.D., Louisville (Central); William O. Preston, M.D., Lexington (Eastern) and Rex E. Hayes, M.D., Glasgow (Western).

W. Vinson Pierce, M.D., Covington, was re-elected KSMA delegate to the AMA for his third term. J. Vernon Pace, M.D., Paducah, was elected alternate delegate succeeding Foster D. Coleman, M.D., Louisville.

Council to Consult Counties Before Calling Meeting of House

The question of when to act on the proposal that KSMA ask the Kentucky Physicians Mutual (Kentucky's Blue Shield Plan) to offer full-payment or service-type coverage was considered at the July 30 open meeting of the Council of KSMA.

The advantages of disseminating more information on the Prepared Plan, in order that members could make up their minds as to what should be done, influenced the Council to set a special meeting of the House of Delegates approximately six months after the Annual Meeting to dispose of the issue.

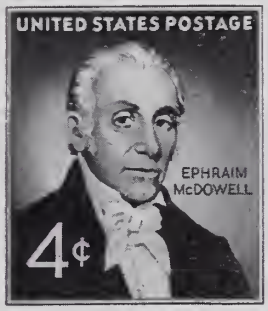
The matter was given further consideration at the September 24 reorganizational meeting of the KSMA Council, according to Carlisle Morse, M.D., its new chairman. At this point, the Council decided to poll the counties after information on the proposal has been published in the November issue of The Journal of KSMA. It was decided that unless there was a substantial amount of interest in the proposal, it would not be necessary to call a special meeting of the House.

W. Vinson Pierce, M.D., Covington, chairman of the KSMA Advisory Commission to Blue Shield, said that both the proponents and opponents of the idea of service-type coverage felt whichever plan was followed, there should be a wide majority to support it.

The advantages and disadvantages of the service-type plan are discussed in the Insurance Department on Pages 1322-23 of this issue of The Journal.

KSMA Cooperates In McDowell Stamp Celebration

Kentucky medicine will be in the national spotlight on December 3 when the 4-cent "Famous American" postage stamp honoring Ephraim McDowell, M.D., is placed on first-day sale at Danville.



The KSMA Council at its September 21 meeting voted unanimously to cooperate with the Boyle County Medical Society, the Kentucky Pharmaceutical Association and leading citizens of Danville in presenting a special program the day the stamp is issued.

Postmaster General Arthur Summerfield and KSMA president, Irvin Abell, Jr., M.D., Louisville, will be the featured speakers. Also invited are Senator Thruston B. Morton, Senator John Sherman Cooper and Congressman John C. Watts, Nicholasville.

The ceremonies will start with an invitational luncheon at Centre College.

It is estimated that some 600,000 McDowell stamps will be sold on the opening day. A special team representing the Post Office Department in Washington will be sent to Danville to assist in the sale.

The first post office west of the Alleghenies was built at Danville, and Doctor McDowell was its third postmaster. This building has been restored and some of the stamps may be sold from it.

Sunlight and Skin to Be Topic of Dallas Symposium Dec. 2

KSMA members attending the American Medical Association's 13th clinical meeting in Dallas, Texas, December 2, will hear a symposium on "Sunlight and the Skin," presented by the AMA's Committee on Cosmetics.

The object of the program is to provide physicians with a survey of current information on all aspects of cutaneous exposure to sunlight, according to Veronica L. Conley, Ph.D., secretary of the committee. Among topics to be discussed will be the sunlight factor in aging and skin cancer, the effectiveness of various physical and chemical sunscreens, the use and abuse of psoralens, and the physical factors in sun exposures.

Stephen Rothman, M.D., University of Chicago, and Raymond R. Suskind, M.D., Kettering Institute, Cincinnati, will serve as co-chairmen.

Speakers will include Rudolph L. Baer, M.D., New York University College of Medicine; Kenneth H. Burdick, M.D., Department of Dermatology, Cleveland Clinics; James B. Howell, M.D., Dallas; S. William Becker, Jr., M.D., University of Illinois, Chicago; Farrington Daniels, Jr., M.D., University of Oregon Medical School, Portland; Allan L. Lorincz, M.D., University of Chicago, and Harold Blum, M.D., professor of biology at Princeton University, Princeton, N. J.

Dr. Morse and Dr. Stevenson Head KSMA Council

Carlisle Morse, M.D., assistant professor of medicine at the University of Louisville School of Medicine, is the new chairman of the KSMA Council. Vice chairman last year, he was elected by unanimous vote of the Council at its reorganization meeting on Thursday, September 24. He succeeds Garnett J. Sweeney, M.D., Liberty, newly-elected vice speaker of the House of Delegates.



Dr. Morse

A native of Caldwell County, Doctor Morse was graduated from Western Kentucky State College and Swarthmore College and received his medical degree from the U. of L. School of Medicine in 1930. He spent four years at the Louisville General Hospital in a rotating internship and residencies in psychiatry and medicine.

He is a member of the KSMA, AMA and SMA, a fellow of the American College of Physicians, and past secretary and treasurer of the Jefferson County Medical Society. He is governor for Kentucky of the American Diabetes Association and former chairman of the KSMA Diabetes Committee.

J. M. Stevenson, M.D., Brooksville, was elected vice chairman of the Council. Doctor Stevenson is secretary of the Bracken County Medical Society and has been active in KSMA affairs for many years.

The Council also organized its seven-member executive committee for the new year. Members by virtue of their offices are the Council chairman and vice chairman and the KSMA president, president-elect and secretary. Elected, in compliance with the by-laws, were Norman Adair, M.D., Covington, Councilor for the Eighth District, and John P. Glenn, M.D., Russellville.

Re-elected for his second three-year term as Councilor for the Third District was Ralph D. Lynn, M.D., Elkton.

Four new Councilors were named: Hugh L. Houston, M.D., Murray, First District; Dixie E. Snider, M.D., Springfield, Fourth District; Thomas O. Meredith, M.D., Harrodsburg, Twelfth District, and William C. Hambley, M.D., Pikeville, Fourteenth District. They succeed, respectively, J. Vernon Pace, M.D., Paducah; W. Keith Crume, M.D., Bardstown; Garnett J. Sweeney, M.D., Liberty, and Charles C. Rutledge, M.D., Hazard.

Blue Shield — Blue Cross Offer New Plan for the Aged

A new coverage designed specifically to meet the needs of the aged in low-income groups has been announced in a joint statement by J. Vernon Pace, M. D., Paducah, chairman of the board of directors of Kentucky Physicians Mutual (Kentucky's Blue Shield Plan), and D. Lane Tynes, president of Kentucky's Blue Cross Plan.

An analysis of this coverage offered by Kentucky's Blue Shield-Blue Cross follows:

Enrollment Period: From November 15 through November 28 only, Blue Shield and Blue Cross are jointly offering a plan for eligible Kentuckians 65 years of age or over.

Enrollment Requirements: The applicant shall be 65 years of age or over, and unemployed, or not eligible for group membership, and in good health. The annual income shall not exceed $1,500 for single persons or $2,500 for man and wife, and resources shall not exceed $15,000 for the single person or $25,000 family. Applications will be underwritten and there will be a twelve (12) month waiting period for any conditions determined to be pre-existing. Other exclusions of the standard Blue Cross-Blue Shield certificates will apply.

Blue Shield Benefits: Allowances for surgery and anesthesia shall be 80% of the Kentucky Physicians Mutual Standard Certificate Schedule of Allowances. Allowances for In-Hospital Medical shall be $15.00 for the first day, $5.00 per day for the next five days, and $3.00 per day for the remainder of 70 days. Diagnostic x-ray schedule if provided in a hospital; or in the hospital out-patient department or doctor's office if hospitalization follows immediately. Radiation therapy allowances shall be 80% of the Kentucky Physicians Mutual Standard Certificate Scheduled Allowances.

Blue Cross Will Provide in full hospital service benefits as follows: operating room, all uses; glucose

(Continued on Next Page)

and saline solutions; all dressings including casts, slings; oxygen including tent and face mask; clinical laboratory examinations done in the hospital, including blood chemistry and cultures; transfusions (not including cost of blood, plasma, substitutes, or procuring same); all drugs and medicines which are officially accepted for general use at the time of such hospitalization, and all examinations and first aid in hospital for non-bed patients in case of emergency accidents only. There will be a $5.00 per day room allowance.

The protection is offered on the basis of single contracts only, and applications must be made for the combination Blue Shield and Blue Cross. The cost to each person accepted as a member will be $11.25 per quarter. There will be a $2.00 enrollment fee for all applicants whose membership is accepted.

Benefits Become Effective January 1, 1960, for those whose applications are accepted. The new member will receive a quarterly bill before January 1, payable in advance.

Dr. Griffith, KSMA Past President, Dies In Owensboro

David Moseley Griffith, M.D., president of the Kentucky State Medical Association in 1907, died at his home in Owensboro on October 9. He was 92 years old.



A native of Owensboro, Doctor Griffith received his medical degree from Tulane University in 1888. After practicing medicine in Owensboro for two years, he went abroad for training as a specialist in eye, ear, nose and throat diseases. He was one of the first to receive the title of Fellow of the American College of Surgeons in 1914.

During the first World War, he served as a member of the Kentucky Board of Surgeons appointed under the National Board of Surgical Committee of the United States Army.

Doctor Griffith was long active in KSMA affairs. Besides being a past president, he was also a former member of the Council.

College of Surgeons Plans Meeting In Louisville Jan. 21-23

About 500 surgeons and related personnel are expected to attend a three-day Sectional Meeting of the American College of Surgeons in Louisville, January 21-23. Headquarters will be at the Brown Hotel.

Rudolph J. Noer, M.D., professor and chairman of the Department of Surgery of the University of Louisville School of Medicine, is chairman of the advisory committee on local arrangements.

Nationally-known guest speakers will include Richard B. Cattell, M.D., Boston; John C. Burch, M.D., Nashville; Ralph A. Reis, M.D., Chicago; Eugene H. Countiss, M.D., New Orleans; Harold G. Scheie, M.D., Philadelphia, and Roscoe J. Kennedy, M.D., Cleveland.

The December issue of The Journal will carry a more detailed program.

Norton Post-Graduate Seminar Scheduled Dec. 17

Eighteen scientific papers are scheduled for presentation at the second Norton Memorial Infirmary Post-Graduate Medical Seminar, December 17, in the Norton auditorium. The program, accepted for four hours Category I credit, is sponsored by the infirmary's board of trustees in cooperation with the Kentucky Academy of General Practice. Seminar chairman is Robert Lich, Jr., M.D.

The morning program, starting at 10 o'clock with James Robert Hendon, M.D., serving as chairman, has been announced as follows:

Some Factors in Calcium Deposition—Jerry M. Shaw, M.D.

Pulmonary Calcification—J. Ray Bryant, M.D.

Calculi of the Gall Bladder—R. Arnold Griswold, M.D.

Calculi Seen by the Rheumatologist—William P. Peak, M.D.

Salivary Calculi—Stuart Graves, Jr., M.D.

General Surgical Approach to Renal Calculi—George B. Sanders, M.D.

Childhood Urolithiasis—John B. Larson, M.D.

Calcification: Its Significance in Vascular Disease — J. Herman Mahaffey, M.D.

Urinary Tract Calculi—Robert Lich, Jr., M.D.

Daryl P. Harvey, M.D., is chairman of the afternoon session:

Use of Steriods in Serious Infections—Robert S. Tillett, M.D.

Ear Problems in General Practice—Arthur L. Juers, M.D.

Office Tonometry—Arthur H. Keeney, M.D.

Surgical Management of Parkinsonism—Everett G. Grantham, M.D.

Problems in I^{131} Uptake Studies for Thyroid Disorders—Gerald M. Peterson, M.D.

Value of Skin Testing in Respiratory Disease—Homer B. Martin, M.D.

Genital Prolapse—Layman A. Gray, M.D.

Psychiatric Treatment in a General Hospital—S. Spafford Ackerly, M.D.

An Evaluation of Isolation-Perfusion Technique in the Treatment of Cancer— Benjamin B. Jackson, M.D.

Dr. Overstreet Succeeds Dr. Sparks As Speaker of the House

Sam A. Overstreet, M.D., Louisville, Centennial president of the Kentucky State Medical Association in 1950-51, was elected speaker of the House of Delegates for a three-year term at the governing body's final meeting of its 1959 session on September 23. He succeeds Clyde C. Sparks, M.D., Ashland, and is the fourth to hold the office of Speaker since the reorganization of procedure in the House of Delegates.



Dr. Overstreet

A 1923 graduate of the University of Louisville School of Medicine, Doctor Overstreet has long been active in medical circles. He is the present governor of the Kentucky Chapter, American College of Physicians, a past president of the Jefferson County Medical Society, and the current chairman of the Advisory Committee to Blue Cross.

Doctor Overstreet has served The Journal of the KSMA in two capacities, first as scientific editorial editor and presently as editor.

Garnett J. Sweeney, M.D., Liberty, succeeds George Pedigo, M.D., Louisville, as vice speaker. Chairman of the KSMA Council the past year, Doctor Sweeney is a former president of the Kentucky Chapter, American Academy of General Practice. He was graduated from the University of Louisville School of Medicine in 1939 and has practiced in Liberty since 1940.

AMA News Marks First Anniversary With Sept. 21 Issue

The first anniversary of The AMA News was occasion for an editorial in the September 21 issue pointing with pride to the newspaper's growth and acceptance by the medical profession since the first issue rolled off the press September 22, 1958. A fortnightly publication, The News was authorized by and is published by the Board of Trustees of the American Medical Association.

During the year, according to the editorial, the paper was widely quoted and reprinted both here and abroad. One recent article was published in 247 daily newspapers and was commented on editorially by 14 others. One short story brought requests for 204,776 pieces of literature.

The main purpose of The News is to keep physicians in touch with the pulse of the medical world and to report on legislation, business trends, legal decisions, tax rulings and other forces that affect the practice of medicine.

$302,758 Pledged by Physicians For U. of L. Development

Physicians have pledged $302,758 toward the University of Louisville's development program, according to a report made at a dinner of the U. of L. Medical Alumni Association held Thursday night, September 24, at the Brown Hotel. This far exceeded the goal of $250,000.

Of the total, $262,568 was contributed by 649 Kentucky physicians. The remainder, $40,190, was given by 104 U. of L. medical alumni who live outside Kentucky. The average pledge was about $500.

The U. of L. is seeking to raise $2,489,585 this year toward a 10-year goal of $25,000,000. Of this year's figure, $1,489,585 is for a new medical-dental research building in the Medical Center. The rest will go toward a physical-education building, books and equipment.

Divided Specialty Groups Praised

Scheduling of the specialty-group sessions on two days of the KSMA's 1959 Annual Meeting gave more physicians an opportunity to attend more of the programs than in former years. Heretofore, all of the specialty sessions were crowded into one day.

Attendance was good, the programs were praised and satisfaction was expressed in the new arrangement. Officials of the specialty groups spoke highly of the facilities at First Christian Church, where most of their programs were presented on Tuesday afternoon, September 22, and Thursday morning, September 24.

Dr. Moore Heads EENT Group

L. P. Moore M.D., Owensboro, is the new president of the Kentucky Eye, Ear, Nose and Throat Society. He succeeds A. H. Keeney, M.D., Louisville.

COMPARATIVE REGISTRATION FIGURES

KSMA Annual Meetings

	1950	1951*	1952	1953	1954	1955	1956	1957	1958	1959
KSMA Members	**713**	**846**	**693**	**786**	**924**	**938**	**923**	**1094**	**971**	**997**
Guest Physicians	126	138	67	75	150	122	157	178	166	165
Interns-Residents	85	101	73	100	148	106	105	142	108	128
Medical Students	155	330	252	292	284	299	305	328	269	280
Registered Nurses	29	27	16	31	25	55	15	28	22	34
Exhibitors	135	204	180	153	174	174	218	176	211	200
Guests	64	189	80	72	166	121	108	151	164	86
Technicians—										
Office Assistants	86	76	49	54	67	50	54	54	45	63
TOTAL ATTENDANCE	**1393**	**1911**	**1410**	**1563**	**1938**	**1865**	**1885**	**2151**	**1956**	**1953**

*KSMA Centennial

Drs. Denham, McLeod and Overstreet Win Golf Trophies

Winners in the Kentucky State Medical Golf Association's 1959 Tournament, held at the Big Spring Golf Club on September 22, 23 and 24, have been announced by Lanier Lukin, M.D., Louisville, chairman of the KSMA Golf Committee.

Ralph Denham, M.D., Louisville, scored low gross to win the championship traveling trophy and a set of silver goblets and tray. Robert McLeod, M.D., Somerset, with low net, was awarded a cup and golf bag. T. J. Overstreet, M.D., Lexington, was the senior championship winner and received a cup.

The low scorer each day was given a dozen golf balls. The winners were: Tuesday, Doctor Overstreet; Wednesday, Robert Hall, M.D., Painstville; Thursday, Paul J. Ross, M.D., Louisville.

The committee awarded more prizes this year than ever before. This also was the first year that committee members were assigned to be at the club to act as hosts to participants in the tournament.

Nominating Committee Named

KSMA's five-member nominating committee for 1960, elected by the House of Delegates, has been announced by Speaker of the House Sam A. Overstreet, M.D., Louisville.

Selected from a list of ten names presented at the final session of the House of Delegates on September 23 were: James W. Archer, M.D., Paintsville; Wendell V. Lyon, M.D., Ashland; Daniel E. Mahaffey, M.D., Louisville; Gaithel L. Simpson, M.D., Greenville, and Frank Hays Threlkel, M.D., Owensboro.

KSMA Supplies Radio, TV Speakers

Radio and TV appearances of guest speakers and members of KSMA on seven programs during the 1959 Annual Meeting were arranged by the KSMA Headquarters staff. These included five half-hour radio programs and one half-hour and one 15-minute program on TV. Other station requests could not be filled because of the tight schedule of the speakers.

Subjects discussed on the air included: Cancer, Public Health Education, Rural Scholarship and Physicians Placement, Compulsory Vaccination and Medicine in the Jet Age.

Another KSMA Service

The special telephone service that KSMA provides at its Annual Meetings to keep physicians in close touch with their offices and homes was used extensively this year.

Approximately 175 calls were recorded during the three-day meeting, September 22-24. Of these, 104 were received at KSMA Headquarters Office at Columbia Auditorium and 47 were taken at the two sessions of the House of Delegates at the Brown Hotel. A number of calls also came in for physicians attending the specialty-group sessions.



OATH OF OFFICE—Garnett Sweeney, M.D., Liberty, left, chairman of the Council, inducts the new president of KSMA, Irvin Abell, Jr., M.D., Louisville, at the 1959 Annual Meeting.



FIRST OFFICIAL ACT—Doctor Abell, as his first official act, presents the past president's key to retiring president, Robert W. Robertson, M.D., Paducah.



CONGRATULATIONS—Doctor Abell congratulates the new Speaker of the House Sam A. Overstreet, M.D., Louisville, center, and Doctor Sweeney, the new Vice Speaker, following the close of the second meeting of the House.

Your Reference Committee System In Action



HARD AT IT — Reference Committee No. 3 considers one of the reports and resolutions referred to it by the House of Delegates the night before at its first session. The committee, chaired by Russell L. Hall, M.D., Wheelwright, seated at table on left, was one of seven that considered the 38 reports and 12 resolutions presented at the 1959 Annual Meeting.



THE WRAPUP — Burford Davis, M. D., Louisville, center, chairman of Reference Committee No. 1, discusses his report with the vice chairman, Lowman C. Trover, M. D., Madisonville, preparatory to dictating it to Mrs. Margaret Wallace, KSMA Headquarters Office secretary.



THE FINAL REPORT — Vice Speaker George W. Pedigo, M. D., Louisville, left, presides at the second session of the House of Delegats on Wednesday evening, September 23, as O. L. Higdon, M. D., Paducah, chairman of Reference Committee No. 5, presents his report.

Resolution on Hospital Care Adopted by KSMA

Because the medical profession has a basic role in ensuring proper and effective utilization of hospital beds and services, the House of Delegates of the Kentucky State Medical Association on September 21 adopted the resolution given below.

The physician decides upon admission, orders diagnostic tests, drugs, treatments and nursing procedures, and determines the period of hospitalization. These decisions affect the scope of hospital facilities, the quality of care and hospital costs. Other factors which also affect hospital utilization include community standards, the patient, hospital management and prepayment plans.

Organized medicine has oficially recognized its key role in utilization of hospital services by resolutions of many State and County Medical Societies. All hospital staffs are urged to set up such committees.

The resolution:

WHEREAS, there is ample evidence of many unnecessary admissions to hospitals and unnecessary prolongation of hospital stays, and

WHEREAS, the constantly rising costs of hospital and medical care is a matter of deep concern to our Association, and

WHEREAS, if these two problems are not solved on a voluntary basis consistent with sound adminstrative and medical practice, the costs of voluntary prepayment plans will be priced out of the reach of those who need them most;

THEREFORE, the Medical Advisory Committee of

(Continued on Next Page)

Defense-Health Official Speaks At President's Luncheon

The far-flung program he administers as Assistant Secretary of Defense for Health and Medicine was described by Frank Brown Berry, M.D., Washington, in an address before KSMA members and guests at the annual President's Luncheon on September 23 at the Brown Hotel.

Doctor Berry spoke at length on his office's activities in the fields of medical education, civil defense and nutrition. He told of an international nutrition study carried on with four other U. S. Government agencies at the request of 20 nations. On the subject of civil defense, he said his office had been made responsible for two types of first-aid packs—one a kit containing 26 items, not requiring medical supervision, and the other a medical pack of 80 items, designed to provide for 1,000 casualties for 20 days.

Housing and hospitalization of wives and families of servicemen stationed abroad also come under the supervision of Doctor Berry's office—a responsibility that took him on a recent trip to Paris and London.

Robert W. Robertson, M.D., Paducah, retiring KSMA president, presided at the luncheon, and introduced distinguished guests. Dr. Kenneth G. Pfifer of the Presbyterian Theological Seminary delivered the invocation and benediction.



GUEST SPEAKER—KSMA members and guests attending the annual President's Luncheon heard Frank Brown Berry, M.D., Washington, Assistant Secretary of Defense for Health and Medicine.



EMCEE—Robert W. Robertson, M.D., Paducah, 1958-59 president of KSMA, presided at the luncheon.

State Surgeons Become Fellows

Seven Kentucky Surgeons were inducted as new Fellows of the American College of Surgeons at Atlantic City, October 2, in ceremonies closing the annual five-day Clinical Congress of the world's largest organization of surgeons. They were among approximately 1,015 surgeons so honored.

The Kentuckians who received the distinction were: Dixon R. McCloy, M.D., Bowling Green; Harold B. Barton, M.D., Corbin; Charles W. Hofman, Jr. Col., Fort Campbell; Robert E. Pennington, M.D., London; G. George Maier, M.D.; Clarence C. Starr, M.D., and Samuel D. Weakley, Jr., M.D., all of Louisville.

Resolutions on Hospital Care

(Continued from Page 1396)

the Kentucky State Medical Association to Blue Cross recommends to the House of Delegates of the Kentucky State Medical Association that the medical staffs in all hospitals set up admission and review committees to accomplish the following:

1. See that only persons who need care are admitted to hospitals;
2. Make sure that patients remain only as long as hospital-type care is required:
3. Plan so that necessary tests and consultations in the hospitals are completed quickly, eliminating every possible delay in the treatment of patients;
4. Make the most efficient use of modern hospital facilities.

KSMA Invited to Hawaii

An invitation to attend the 104th Annual Meeting of the Hawaii Medical Association in Honolulu, May 12-15, 1960, has been extended to all members of the Kentucky State Medical Association.

Since this will be HMA's first Annual Meeting under statehood, an exceptional program of scientific and social events is being planned, according to Toru Nishigaya, M.D., president. "We hope your members will be able to attend and help us celebrate this occasion," he writes.

UK Dental School Bids Due Nov. 17

Bids for construction of the new dental school at the University of Kentucky Medical Center in Frankfort are scheduled to be opened on November 17, according to published reports. The seven-story building, estimated to cost between $2,000,000 and $3,000,000, will be added as a wing to the hospital now under construction.



NEW MEMBERS—These are some of the first-year members who were guests of the Kentucky State Medical Association at the first new-member luncheon held on September 22 at the Brown Hotel. N. L. Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Services, presided. Seated, clockwise, are Charles E. Peck, M.D., Russell Springs; Lewis E. Wesley, M.D., Liberty; Keith Kirby, M.D., Burkesville; Tom E. Hall, M.D., and Arthur H. Isaacs, M.D., Louisville; W. A. Cole, Jr., M.D., Radcliff, and L. W. O'Bannon, M.D., Elizabethtown.

33 Attend KSMA's First Luncheon Honoring New Members

Thirty-three physicians were guests of the Kentucky State Medical Association at a special luncheon honoring new members, September 22, in the Louis XVI Room of the Brown Hotel. The number represented almost one-third of the 110 physicians who joined KSMA during the year beginning September 1, 1958.

N. Lewis Bosworth, M.D., Lexington, chairman of the KSMA Committee on Public Information and Services, was moderator of the program designed to acquaint the new members with the purposes and inner workings of KSMA. Participants and their topics were: Carl H. Fortune, M.D., Lexington, "The Purpose of KSMA"; Hoyt Gardner, M.D., Louisville, "Services KSMA Renders to Its Members," and Garnett Sweeney, M.D., Liberty, "Services KSMA Renders to the Public."

The luncheon, a new feature of the Annual Meeting this year, was termed such a success that the House of Delegates voted to make it an annual affair.

Mrs. Roles Named President-Elect Of Medical Auxiliary

Mrs. Earl W. Roles, Louisville, was elected president-elect of the Woman's Auxiliary to the Kentucky State Medical Association at the Wednesday morning session of the group's 37th Annual Meeting held at the Brown Hotel, September 22, 23 and 24.

Mrs. Charles B. Johnson, Russell, was installed as president. She succeeds Mrs. J. Andrew Bowen.

Other officers elected were: Mrs. Hugh Mahaffey, Richmond; Mrs. C. J. Haebele, Russell; Mrs. Guy Morford, Owensboro, and Mrs. Keith Smith, Corbin, vice presidents; Mrs. Bennett McWhorter, Ashland, corresponding secretary; Mrs. Merle Mahr, Madisonville, recording secretary, and Mrs. R. O. C. Green, Bowling Green, treasurer.

The Auxiliary's annual health-citation award was presented to the Playladies of the Spastic School and Home, Inc., Owensboro.

U.K. College of Medicine Forming Inaugural Class of 1960

The inaugural 1960 class of the University of Kentucky's first College of Medicine is now being formed, with acceptance notices mailed to some of the more than 130 prospective physicians who have applied for admission.

Between 200 and 300 applications are expected for the first class, the College of Medicine admissions office has announced. The maximum number the university can accept is 75.

A prospective medical student should write to the university about a year before he hopes to enroll in the College of Medicine. He will be sent an application form which he will return, along with two recommendations from undergraduate professors and a transcript of his college work. An invitation is then sent to the applicant to appear at the university for a personal interview.

New KSMA Members Listed

The following names have been added to the KSMA membership roster:

T. W. DeMunburn, M. D., Louisville
Donald G. Diehold, M. D., Louisville
Don L. Harmon, M. D., Louisville
Albert B. Harris, M. D., Louisville
Jack A. Schecter, M. D., Louisville
Merrill A. Winchester, M. D., Whitley City

Synonyms for Pain Relief...

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Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½

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No. 1
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ⅛

No. 2
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ¼

No. 3
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. ½

No. 4
Acetophenetidin ..... gr. 2½
Acetylsalicylic Acid .... gr. 3½
Caffeine ..... gr. ½
Codeine Phosphate .... gr. 1

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IN

simple headache
rheumatic conditions
arthralgias
myalgias
common cold
toothache
earache
dysmenorrhea
neuralgia
minor trauma
tension headache
premenstrual tension
minor surgery
post-partum pain
trauma
organic disease
neoplasm
muscle spasm
colic
migraine
musculo-skeletal pains
postdental surgery
post-partum involution
fractures
synovitis/bursitis

relief of pain
of all degrees of
severity up to
that which
requires morphine

AND IN

fevers
dry,
unproductive coughs



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Three KSMA Awards Presented At President's Luncheon

A Lexington surgeon, a Lynch physician and a Maysville health official won the 1959 awards of the Kentucky State Medical Association. Presentation of the citations, a highlight of each Annual Meeting, was made at the President's Luncheon, September 23, in the Crystal Ballroom of the Brown Hotel.

The Distinguished Service Medal went to Francis Massie, M.D., who has been associated with the Lexington Clinic as surgeon since 1924; the Outstanding General Practitioner Award to Leland E. Payton, M.D., who retired in August after practicing in the Cumberland Mountains for 35 years, and the R. Haynes Barr Award to James R. Sills, administrator of the Mason County Health Department.

Because of a heart attack suffered on September 9, Doctor Payton was unable to be present to receive the honor. This was the first time in 35 years, except during World War II, that he had missed an Annual Meeting.



GETS SERVICE MEDAL—Francis Massie, M.D., Lexington, right, was awarded KSMA's Distinguished Service Medal for 1959. Woodford B. Troutman, M.D., Louisville, KSMA secretary, made the presentation of the Association's awards.

Doctor Massie was born in Shanghai, China, the son of an Episcopal missionary who later became rector of Christ Church in Lexington. He received his medical degree from the University of Virginia in 1919, after which he spent three years in surgical training at St. Luke's Hospital and the Sloane Hospital for Women in New York. He began the practice of medicine in Lexington in 1922, joining the Lexington Clinic two years later.

Doctor Massie is active in medical affairs. He was one of the founders of the Kentucky Medical Foundation, formed in 1954 to work for a medical school at the University of Kentucky. He helped organize the Kentucky Surgical Society. He is co-chairman of the KSMA McDowell Home Committee. Also a civic worker, he has been a member of the Lexington Board of Education for 20 years, six of which he served as chairman.

Doctor Payton, a native of Horse Cave, was graduated from the University of Kentucky, served as a machine gun officer in World War I, then entered the University of Louisville School of Medicine, receiving his medical degree in 1923. After an internship at Louisville General Hospital, he located at Lynch in the Cumberland Mountains. He delivered over 2,000 babies during his 35 years of practice.



GP AWARD BY PROXY—E. M. Howard, M.D., Harlan, right, accepted the Outstanding General Practitioner Award for the recipient, Leland E. Payton, M.D., Lynch, who was unable to attend because of illness.

Doctor Payton entered the Army Medical Corps in World War II at the age of 51. He was chief of the Orthopedic Service at Fort Knox for two years. He helped organize some of the early mobile hospital units in the Pacific, earned a Battle Star at Okinawa, served as chief of orthopedics at an Army Hospital in Japan, and was chief of the General Surgical Service for a short time. He emerged after 49 months with the rank of lieutenant colonel.

Active in medical organizations, Doctor Payton is also a civic leader. He has been a member of the Lynch Independent School Board for 10 years and its chairman for six years. He has served on the County Board of Health for 10 years.

Mr. Sills is the second layman to receive the R. Haynes Barr Award, named in honor of the father

(Continued on Next Page)



LAYMAN HONORED—James R. Sills, Maysville, administrator of the Mason County Health Department, was the second recipient of the R. Haynes Barr Award given for public service.

KSMA Awards Presented

(Continued from Page 1401)

of KSMA's public service efforts. The late James F. Blackerby won the first award in 1958.

A native of Hardinsburg, Breckinridge County, Mr. Sills was appointed sanitarian of the Daviess County Health Department in November, 1943, with responsibility of setting up a food inspection program in Owensboro and Daviess County. In 1951, he joined the State Department of Health as administrative assistant to the director of the Division of Local Health Services. He became administrator of the Mason County Health Department in September, 1955.

Mr. Sills is a charter member of the Kentucky Section of the National Association of Sanitarians and a charter member and present vice president of the Kentucky Public Health Association. He has served the Health Officers and Administrators Section of the latter association as president, program chairman and secretary.

KSMA Cooperates In Revising Rehab Fee Schedule

When the Department of Education set up the Bureau of Rehabilitation Services in the middle to late 1940's, a fee schedule was adopted.

Officials of the department, along with its medical director, T. P. Leonard, M.D., Frankfort, felt that the schedule had become unrealistic, and the KSMA Associate Committee on Physical Medicine and Rehabilitation was asked to cooperate with the department in revising it.

At a recent meeting of the committee, according to Doctor Leonard, it was decided that a relative value scale be used in determining the fees. Doctor Leonard said officials of the rehabilitation bureau were pleased with this action.

Dr. Grise of Bowling Green Heads Cancer Society

Richard F. Grise, M.D., Bowling Green, was elected president of the Kentucky Division of the American Cancer Society at the group's annual meeting in Louisville on September 10. He succeeds Henry B. Asman, M.D., Louisville, who served two years.

Elected vice presidents were Wesley G. Farnsley, M.D., Louisville; Porter Mayo, M.D., Lexington, and Richard J. Wever, M.D., Paris.

Five new professional board members were named: Stuart Graves, Jr., M.D., and Robert C. Long, M.D., both of Louisville; Coleman C. Johnston, M.D., and Kenneth D. McGinnis, M.D., both of Lexington, and Edward B. Mersch, M.D., Covington.

Grants totaling $104,988 for the new fiscal year have been announced by Doctor Grise. Awards to hospitals were: St. Joseph Infirmary, Louisville; $33,376; St. Joseph Hospital, Lexington, $18,060; Good Samaritan Hospital, Lexington, $19,700; King's Daughters Hospital, Ashland, $1,800; Jennie Stuart Memorial Hospital, Hopkinsville, $1,000; Methodist Hospital, Pikeville, $2,000; Red Cross Hospital, Louisville, $1,000; Bowling Green-Warren County Hospital, $3,400, and William Booth Memorial Hospital, Covington, $10,152.35.

The U. of L. School of Medicine was given $10,000 for professional education and the Rehabilitation Center, Louisville, $4,500 for the salary of a teacher of laryngectomy patients.



POST-MORTEM—Herbert Sloan, M.D., Ann Arbor, Mich., left, and Nelson K. Ordway, M.D., New Haven, Conn., speakers at a joint meeting of the Kentucky Chapters, American College of Chest Physicians and American Academy of Pediatrics, discuss with Joseph A. Little, M.D., right, associate professor of pediatrics at the University of Louisville School of Medicine, a panel just presented at the 1959 Annual Meeting.

UK Research Fund Group Named

A five-man committee has been named to direct the new Fund for Advancement of Education and Research in the University of Kentucky Medical Center. Dr. Frank G. Dickey, president of the university, is chairman of the group.

Articles of incorporation define the purposes of the organization as "promoting, receiving, administering, investing and granting of funds" to be used for "educational, research, charitable, and other purposes" of the Medical Center. The organization "shall have no part of the purpose, power or activity of this corporation to carry on propaganda or otherwise to attempt to influence legislation."

Dr. McPheeters Named to Post

H. L. McPheeters, M.D., Commissioner of the Kentucky Department of Mental Health, has been appointed to a 12-member committee on planning for mental health facilities throughout the United States. Named by Surgeon General Leroy E. Burney, the group will help the U. S. Public Service draw up treatment and administrative guides for mental hospitals.

KAGP Seminar Set for Jan. 21

The Northern Kentucky Seminar of the Kentucky Academy of General Practice will be held on January 21 at the Sheraton-Gibson Hotel in Cincinnati. Paul E. Muncy, M.D., Covington, is chairman of arrangements. Southern Ohio physicians will be invited to attend.

Importance of Teamwork to Defeat the Forand Bill Stressed at AMA Legislative Conference in St. Louis

Approximately 250 representatives from 49 states attended the Legislative Conference sponsored by the Council on Legislative Activity of the American Medical Association, at the Statler-Hilton Hotel in St. Louis, Friday and Saturday, October 2 and 3.

KSMA was represented by its President, Irvin Abell, Jr., M.D., and the Chairman of the Council, Carlisle Morse, M.D., both of Louisville, in addition to the Chairmen of the Legislative Committee—Chairman for National Affairs, George Archer, M.D., Prestonsburg, and Chairman for the State Affairs, Wyatt Norvell, M.D., New Castle. The executive secretary was also in attendance.

The conference was opened by George M. Fister, M.D., Chairman of the AMA Council on Legislative Activities. He said that it had two purposes. One was to discuss the Forand Bill and the other to look into political activities of medical societies. He urged that all physicians become fully acquainted with the Forand Bill.

History Reviewed

History of the Legislative Activities was reviewed by Kenneth Sawyer, of Denver. He closed his talk by giving five qualities he thought each state legislative key man should have. First, he should be a coordinator. Second, he would be properly appointed. Third, he would be able to call in all groups—medical and otherwise. Fourth, he must be well informed. Fifth, he must have a "thick hide." He concluded his talk by stressing the need for individual activity on the part of each physician, etc.

"Legislative Teamwork" was discussed by AMA's Executive Vice-President, F. J. L. Blasingame. Stressing the need for teamwork, he said we as physicians must use "our time, tact, wisdom, and influence" to properly influence legislation. He pointed out that physicians see approximately 1,300,000 people a day in a professional way, which does not include contacts made in a business and social way. He adjured his audience to go home and lead their colleagues in a full realization of their responsibility as citizens.

"The Washington office, big or little, cannot control legislation," he said. "I want to emphasize it is most essential and important that we turn our attention to where legislators are made, not where laws are made. Politicians live and die by votes—back home."

He warned against physicians accepting creeping socialism, the Forand Bill and other threats as "the doctrine of inevitability." He stated that we "can win if we work as a team and if we think big."

Doctor Blasingame told his listeners not to discount the power of the support for the Forand Bill. He said many politicians want "a political solution" to this problem and are searching for votes. He reminded his audience that politicians live and die politically by votes.

He stressed the need for creating a political climate at the grass roots, in which the voters would elect men who would go to Washington and vote for laws that are in the public interest.

Raymond L. White, M.D., then moderated a panel entitled "HR-4700—What Has Been Done." The first panelist, Mr. Aubrey Gates, pointed out that we were fighting this battle on the other man's field and on the other man's timetable. As an example, he pointed to the difficulties of learning just when and how the hearings on the Forand Bill would be held, after receiving assurances that they would not be held.

Joe Stetler, Secretary of the Council on Legislative Activities, said there were 64 witnesses that appeared on the Forand Bill: 28 for, 32 against, and four took no position. He then discussed the effectiveness of the various key witnesses on both sides. He stated that some of the strongest testimony given was presented by the American Hospital Association. The only member of the health team that supported the legislation was the representative of the American Nursing Association. Podiatrists and osteopaths, while appearing neutral, indicated that if the Bill was passed, they felt they should be included.

Leo Brown, Director of the Division of Communications, gave a detailed discussion of the part that the Division had played in publicizing the hearings; cooperating with the states who sent delegations and sending releases to the local press back home. Mr. Brown's presentation was very effective and well received.

Lay Activities Discussed

John Guy Miller, who has been assigned to the Assistant Vice-President, discussed activities in lay circles and allied groups. He said there were three objectives in the AMA program that were important. First, realistic attitude toward the aging; second, improvement of facilities in services for the aged; and third, the financing of health care.

In the question-and-answer period, Mr. Brown said that physicians should work with "local" labor groups, pointing out that many times the local members did not share the point of view of the national leaders. Mr. Gates and Mr. Brown both deplored the fact that physicians generally refuse to be interested in legislative matters.

Other points made were that the physicians' forum, made up largely of physicians in the East and New York, supported Forand legislation. Labor claims management has not been responsive to the needs of retired workers.

Robert E. Smylie, Governor of Idaho, was the luncheon speaker. He is one of the youngest men in history ever to be elected to the governorship of a state.

"You will never be effective in politicol activity until you ore willing to get personolly involved," he soid.

His second point was that, "You must be willing to back your ideas in politics financially as strongly as you are willing to back your golf."

He stressed the need for getting behind something affirmatively. He urged that physicians "put their neck on the line" and went on to explain, "You don't hear a trumpet that blows softly." He said, "You can't have everything the way you want it."

He stressed the terrific cost of conducting political campaigns, and said that to date no effective barrier to this has been found. He urged the medical profession to actively support its candidates and stated that "people who have a stake in Americanism must awaken to the fact that they have a responsibility to see men of integrity are elected to political office.

Dr. Alford, a Speaker

The first speaker of the afternoon session was Congressman Dale Alford, M.D., of Arkansas (he is one of five physicians serving in the Congress).

Doctor Alford stated that physicians should not lean on AMA to look after all of their legislative matters, but they should accept the responsibility back home to talk to their Congressman. He pointed out that down through the years, medicine has "sat on hand" and as a result, we have Forand-type legislation, which is now such a threat.

He agreed with Governor Smylie that the profession should support the man of their choice in a substantial way. Congressmen, he stated, are not getting rich; and they need support. He said physicians should know, for instance, what it costs a man running for Congress to buy newspaper advertising and to purchase time on television and radio, and all of the other expenses involved in conducting a successful campaign.

Doctor Alford concluded his effective remarks with this admonition, "We reap the results of the battle we fought, whether we win or lose."

The afternoon panel entitled, "HR-4700—What Will Be Done" was under the direction of Frank C. Coleman, M.D. Some of the high points in this panel were: that Congress convenes on January 7, and any day after that the Forand Bill could be called out of the House Ways and Means Committee for debate and vote on the floor of the House.

Again the need for having physicians generally informed on the Forand Bill was emphasized. Also, advantages to giving information to the members of hospital staffs and boards of trustees and hospital administrators on the Forand Bill were stressed. It was explained that the AMA has put together 1,500 kits for county medical societies' use. One side of the kit was to provide information for physicians and suggested courses of action. The other side was to be used in an education campaign of the public. Effective and intelligent use of these kits was urged.

The last member of the panel, Ernest B. Howard, M.D., Assistant Executive Vice-President of the AMA, discussed the activities of the proponents of the Forand Bill, highlighting their divide-and-conquer techniques. He described the efforts that had been made to cause a defection of the American Hospital Association, Blue Cross-Blue Shield, health insurance industry and management.

He pointed out that proponents of the Bill were attacking the AMA at every possible opportunity, doing their best to destroy the image of this organization, because they recognize it as the strongest single force opposing the Forand Bill. He said every effort is being made to create the idea among members of Congress that those who favor the Forand Bill have the weight of actuarial knowledge.

Repetition o Technique

Another one of the techniques is to repeat and repeat and repeat that it is inevitable, that Forand legislation is bound to come. At the same time, proponents seek to soften the opposition by repudiating the Waggner-Murray-Dingle Bill, etc. It was pointed out that the strikes in hospitals around over the country were a definite effort to increase the cost of hospital care and it was felt that this was all tied in with Forand legislation.

It was again emphasized that the socialistic view had infiltrated labor, some members of the AMA, some members of the AHA, nurses, and any place that they might—with the view of creating a climate for favorable action on the Forand and McNamara measures. It was also suggested that as the second session of the 86th Congress progresses that certain commentators, newspapers, and publicity sources will suddenly become disturbed about the "plight of the aged" and start an all-out campaign for the enactment of the Bill. Doctor Howard said our opposition was very smart indeed and "unbelievably patient."

In the question-and-answer session that followed, the point was made that this fight can be won only if all county and state medical societies work together. The need of sending "thoughtful" personally-written letters to your Congressman was emphasized. (Avoid use of "canned material")

The first number on the Saturday morning program was a mock hearing of the House Ways and Means Committee. A "Congressional Committee" questioned two "witnesses" in the persons of Doctors David B. Allman and George E. Twente. The demonstration was carried on in the same way that the House Ways and Means hearings were held, and proved to be a very worthwhile presentation.

A panel entitled "Political Action by Organized Medicine" was moderated by J. Lafe Ludwig, of the A.M.A. Council on Medical Services.

One of the panelists, Roger Fleming, of the Amerlcon Farm Bureau, urged his oudience to "make no opology for being what you ore for. When you ore for the system, you ore agoinst anyone who tinkers with it. If there is o fire bug in the community who is causing oll sorts of domage and who can burn down property foster thon you con build it, you naturally wont to see him stopped. You moke no apology for it."

While he pointed to the advantages of having an affirmative attitude, he said that nine of the Ten Commandments start with "Thou shalt not." He said, "If you are for something, what is wrong with being against those who would take it away from you?"

It was suggested that the medical profession take more of an interest in local and state politics, with respect to the selection of delegates to the Presidential candidates. Both parties should participate in this effort.

Physicians were again urged to contribute to the campaign of candidates whom they supported. It was felt the best method was to personally deliver their contribution to the hand of the candidate.

Conference Urged as Pattern

In conclusion, Doctor Blasingame once more emphasized the importance of working as a team. He said he hoped that what had been done in St. Louis would set a pattern for efforts by various state medical associations to follow.

He said members of Congress are not insensitive to who may elect them in the future. In talking about what might be done to defeat the Forand Bill, he again urged physician participation.

The final speaker of the Conference was Congressman Thomas B. Curtis of Missouri. Mr. Curtis told his audience that what we have today is a result of what those did before us, and what we are doing today will be a legacy for those that are to follow. He said that citizenship is a trusteeship for those who can't vote, the young and old, and the coming generations who can't vote.

He pointed out that the technique of Fabian socialism is, to quote "If a man does not agree with you, then smear him."

Integrity of Profession Attacked

The idea is to attack the integrity of the profession and not the ideas of the profession. Mr. Curtis pointed out that some of the top leaders in labor were not actually labor leaders, but were politicians who were very adroit and realized some years back that political power in the future would come through control of labor unions. To support this, he said that he had seen labor leaders sell their constituency down the river many times, in order to concentrate power in the Federal Government.

Again, he urged his listeners to be active in both parties. He pointed out that the rank-and-file politician was honorable and upright, and just as eager to do the right thing for his country as any member of the law or medical profession, or any other group. He said we should get away from the idea of using the term of "politician" or "lobbyist" in a disparaging way. He said that he felt that both the politician and the lobbyist were very essential to good Democratic Government.

G. W. Schwert, M.D., a University of Kentucky biochemist, has received a $72,000 heart-study grant from the National Health Institute, according to news dispatches. Doctor Schwert will use the grant to study the way a heart enzyme works to convert lactic acid into pryuvic acid.

More Eastern Kentucky Physicians Advocated by EKRPC

How to obtain more physicians for Eastern Kentucky was one of the health and welfare topics discussed at a meeting of the Eastern Kentucky Regional Planning Commission held on successive days at London and Manchester, September 28 and 29.

Representing the Kentucky State Medical Association at the meeting were W. E. Becknell, M.D., Manchester; E. C. Seeley, M.D., London; Willard Buttermore, M.D., Corbin; Russell Hall, M.D., Wheelwright, and Bobbie R. Grogan, Director of Field Services, KSMA Headquarters Office. Alex Spencer, M.D., West Liberty, and William C. Hambley, M.D., Pikeville, took part in a pre-planning session on September 23 but were unable to attend the two-day meeting.

The EKRPC is a statutory, authorized group of nine, appointed by the Governor. The committee, with John D. Whisman as executive director, is charged with formulating a comprehensive program for Eastern Kentucky in the field of spiritual values, forestry, agriculture, education, health and welfare, community development, industrial development, legislation and communication. Doctor Spencer is a member of the committee.

Mr. Whisman summarized the two-day program as follows:

1. Establishment of an aggressive information and education program by setting up special short courses in public health for Eastern Kentucky public-school teachers and planned distribution of essential public-health information to professional and civic leaders of the region.

2. Establishment of special training programs to allow for scholarships and public-health and welfare careers; extension courses for existing public-health and welfare workers; establishment of professional degree courses in public health and social welfare for Kentucky students.

3. Expansion of both the employment-placement service and the vocational-training program and a closer co-ordination between the two.

4. Establishment of a program to give a beginning doctor access to capital on a long-term-loan basis to permit him to purchase basic clinic facilities for his office, so that such facilities can be provided in more communities where regular hospital service is not available.

5. That the Eastern Kentucky Commission create an advisory council for health and welfare, so the commission can take a continuing look at existing programs and thus enable it to meet the needs of the region.

150 Attend KAGP Seminar

Approximately 150 physicians and their wives attended the annual Postgraduate Seminar sponsored by the Kentucky Academy of General Practice, at Kenlake Hotel, Hardin, on October 22, according to Daryl P. Harvey, M. D., Glasgow, KAGP president. Tennessee physicians were invited.

Was Your Delegate Present?

ROLL CALL—1959 House of Delegates*

KSMA Annual Meeting

	OFFICERS	First Session	Second Session
Speaker	Clyde C. Sparks	Present	Present
Vice Speaker	George W. Pedigo, Jr.	Present	Present
President	Robert W. Robertson	Present	Present
President-Elect	Irvin Abell, Jr.	Present	Present
Vice President	Marvin A. Lucas	....	Present
Vice President	Thomas O. Meredith	Present	Present
Vice President	L. Focian Beasley	....	....
Secretary	Woodford B. Troutman	Present	Present
Treasurer	Delmas M. Clardy	Present	Present
Delegate to the AMA	W. Vinson Pierce	Present	Present
Delegate to the AMA	Robert C. Long	....	....
Alternate Delegate to the AMA	Foster D. Coleman	Present	....
Alternate Delegate to the AMA	George P. Archer	Present	Present

COUNCILORS

District			
First	J. Vernon Pace	Present	Present
Second	Walter L. O'Nan	Present	Present
Third	Ralph D. Lynn	Present	Present
Fourth	W. Keith Crume, deceased		
Fifth	Carlisle Morse	Present	Present
Sixth	John P. Glenn	Present	Present
Seventh	Wyatt Norvell	Present	Present
Eighth	Norman Adair	Present	Present
Ninth	J. M. Stevenson	Present	Present
Tenth	Richard G. Elliott	....	....
Eleventh	Joe M. Bush	Present	Present
Twelfth	Garnett J. Sweeney	Present	....
Thirteenth	Charles B. Johnson	Present	Present
Fourteenth	Charles C. Rutledge	....	....
Fifteenth	Keith P. Smith	Present	Present

PAST PRESIDENTS

1957	Edward B. Mersch	Present	Present
1956	Richard R. Slucher	....	Present
1955	J. Gant Gaither	....	....
1954	Clyde C. Sparks**	Present	Present
1953	J. Duffy Hancock	Present	Present

DELEGATES

First District

County		First Session	Second Session
BALLARD	Jesse M. Hunt	Present	....
CALLOWAY	A. D. Butterworth	Present	Present
CARLISLE			
FULTON	G. F. Bushart	Present	....
GRAVES	W. B. Simpson	....	....
	William Fuller (Alternate)	....	Present
HICKMAN	V. A. Jackson	....	....
LIVINGSTON			
McCRACKEN	Walter Johnson	Present	Present
	Walker Turner	Present	Present
	Leon Higdon	Present	Present
MARSHALL	William J. Colburn	....	....

Second District

DAVIESS	L. P. Moore	Present	....
	H. J. Davis (Alternate)	Present	Present
	A. B. Colley (Alternate)	Present	Present
HANCOCK			
HENDERSON	J. L. Tanner	....	....
McLEAN	Samuel E. Scott	....	....
OHIO	Oscar Allen	Present	Present
UNION			
WEBSTER			

Third District

CALDWELL	B. K. Amos	Present	....
CHRISTIAN	Harvey B. Stone	Present	Present
	Gabe A. Payne, Jr.	Present	Present
CRITTENDEN	R. M. Frandon	....	....
HOPKINS	Loman C. Trover	Present	....
	F. A. Scott	Present	Present
LYON	John E. Cotthoff	Present	Present
MUHLENBERG	G. L. Simpson	Present	....
	G. F. Frockman (Alternate)	....	Present
TODD	Robert A. Clary	Present	Present
TRIGG	John Futrell	Present	....

Fourth District

BRECKINRIDGE	W. R. Morris	....	....
BULLITT	P. J. Murphy	Present	....
GRAYSON	P. A. O'Neill	....	....
GREEN	Robert Shuffett	Present	Present
HARDIN	R. T. Routt	Present	Present
	Leo C. McCampbell	Present	Present
HART	J. D. Handley	....	....
LARUE	David Drye	Present	Present
MARION	George E. Clark	....	....
MEADE	J. J. Sonne	Present	Present
NELSON	M. H. Skaggs	Present	....
SPENCER	H. F. Chambers	Present	Present
TAYLOR	R. A. Hamilton	Present	Present
WASHINGTON			

Fifth District

JEFFERSON	L. Douglas Atherton	Present	Present
	McHerny S. Brewer	....	Present
	Eugene M. Holmes (Alternate)	Present	....
	W. Burford Davis	Present	Present
	Robert S. Dyer	Present	Present
	Edward Warrick (Alternate)	Present	Present
	John J. Robbins	....	....
	Hoyt Gardner (Alternate)	....	Present
	L. H. Segerberg	Present	Present
	Samuel Weakley, Jr.	Present	Present
	Carroll L. Witten	Present	Present
	Benjamin D. Boone	....	....
	Byron Bizot (Alternate)	Present	....
	Robert O. Joplin (Alternate)	....	Present
	J. Randolph Buskirk	Present	Present
	Rudy J. Ellis	Present	Present
	Thomas V. Gudex	Present	Present
	Robert L. McClendon	Present	Present
	Alfred O. Miller	Present	....
	F. Albert Olash	Present	Present
	William P. Vonderhaar (Alternate)	Present	Present
	Rudolph F. Vogt	Present	....
	Eugene M. Holmes (Alternate)	....	Present
	Everett H. Baker	Present	Present
	William Buschemeyer	Present	Present
	Kenneth P. Crawford	Present	Present
	Nathan I. Handelman	Present	Present
	Jack Hellman	Present	Present
	Daniel E. Mahaffey	Present	Present
	Henry Post	Present	Present
	Stanley E. Smith	....	....
	Harvey C. Hardegree (Alternate)	....	Present
	Robert S. Tillett	Present	Present

Sixth District

ADAIR	James C. Salato	Present	....
ALLEN	Owen Davis	....	....
	John W. Meredith (Alternate)	Present	....
BARREN	William Bryant	Present	Present
BUTLER	D. G. Miller, Jr.	Present	....
CUMBERLAND	Joseph Schickle	....	....
EDMONSON			
LOGAN	C. V. Dodson	....	Present
METCALFE	E. S. Dunham	....	Present
MONROE	James Carter	....	....
SIMPSON	L. F. Beasley	Present	Present
WARREN	Harold Keen	Present	Present
	Keith Coverdale	....	Present

Seventh District

ANDERSON	Boyd Caudill	....	....
CARROLL	J. O. Mattax	Present	Present
FRANKLIN	John B. Clay	Present	Present
GALLATIN	G. F. Harris	....	....
GRANT	Lenore P. Chipman	Present	Present
HENRY	G. E. McMunn	Present	....
OLDHAM	Burl Mack	Present	Present
OWEN	O. A. Cull	....	....
SHELBY	Donald Chatham	Present	Present
TRIMBLE	Carl Cooper, Jr.	Present	Present

Eighth District

BOONE	Gladys L. Rouse	Present	Present
CAMPBELL-KENTON	Richard Rust	Present	Present
	J. J. Rolf	Present	Present
	W. R. Houston	Present	Present
	R. J. Hoffman	....	Present
	Carl Kumpe	....	....
	W. T. McElhinney (Alternate)	....	Present
	J. Humpert	....	....
	Robert C. Longshore (Alternate)	....	Present

Ninth District

BATH			
BOURBON	William Cox	....	Present
BRACKEN	Carl A. Marquardt	....	....
FLEMING	R. W. Fidler	Present	....
HARRISON	J. P. Wyles	....	....
MASON	Harry C. Denham	Present	Present
NICHOLAS			
PENDLETON	Robert L. McKenney	....	....
ROBERTSON	Perry Overby	....	....
SCOTT	C. R. Lewis	Present	Present

Was Your Delegate Present?

ROLL CALL—1959 House of Delegates*

		Session First	Session Second
	Tenth District		
FAYETTE	C. C. Johnston	Present	....
	N. L. Bosworth	Present	Present
	Robert B. Warfield	Present	Present
	Robert D. Shepard	Present	Present
	Carl H. Fortune	Present	Present
	Maurice Kaufmann	Present	Present
	D. E. Scott	Present	Present
	R. M. Slabaugh	Present	Present
JESSAMINE	J. S. Williams	....	Present
WOODFORD	F. D. Willey	....	....
	Ben F. Roach (Alternate)	Present	....
	Eleventh District		
CLARK	Earl B. Rynerson	Present	....
ESTILL	R. R. Snowden	....	....
JACKSON			
LEE	J. M. Smith	....	....
MADISON	Douglas Jenkins	Present	....
	Hubert C. Jones	....	Present
MENIFEE	D. L. Graves	....	....
MONTGOMERY	William McKenna	Present	Present
OWSLEY	M. B. Gabbard	....	Present
POWELL	S. T. Scrivner	....	....
WOLFE	Milton O. Beebe, Jr.	Present	Present
	Twelfth District		
BOYLE	Chris Jackson	....	....
CASEY	Lewis Wesley	Present	....
CLINTON	Ernest A. Barnes	....	....
GARRARD	Paul Lett	Present	Present
LINCOLN	H. I. Frisbie	....	....
McCREARY	H. A. Perry	....	....
MERCER	T. O. Meredith	....	....
	E. H. John (Alternate)	Present	Present
PULASKI	A. L. Cooper	Present	Present
ROCKCASTLE	R. E. Arnold	....	....
RUSSELL			
WAYNE	R. B. Breeding	Present	....
	Thirteenth District		
BOYD	Phillip J. Winn	....	....
	W. V. Lyon	Present	Present
CARTER	J. Watts Stovall	Present	Present
ELLIOTT	John F. Greene	....	....
GREENUP	Billy Riddle	Present	Present
LAWRENCE	William J. McNabb	....	....
LEWIS	Elwood Esham	....	....
MORGAN	Alex Spencer	....	Present
ROWAN			
	Fourteenth District		
BREATHITT			
FLOYD	Russell L. Hall	Present	Present
JOHNSON	James W. Archer	Present	Present
KNOTT	M. F. Kelly	Present	....
LETCHER	T. M. Perry	Present	Present
MAGOFFIN	Lloyd M. Hall	....	Present
MARTIN			
PERRY	C. H. Williams	Present	....
PIKE	W. C. Hambley	....	Present
	Ballard W. Cassady (Alternate)	Present	....
	Fifteenth District		
BELL	Charles B. Stacy	Present	Present
	T. K. Mahan	....	....
	William L. Donham (Alternate)	....	Present
CLAY	W. E. Becknell	....	Present
HARLAN	E. M. Howard	Present	Present
	Philip J. Begley	....	....
	Sanford Weiler (Alternate)	Present	....
KNOX	H. L. Pushey	Present	Present
LAUREL	Boyce E. Jones	Present	Present
LESLIE			
WHITLEY	W. M. Buttermore	Present	Present
TOTAL		130	123

**The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings on Sept. 21-23.*

***Previously counted as Speaker of the House.*

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

March 1, 2, 3, and 4, 1960

Palmer House, Chicago

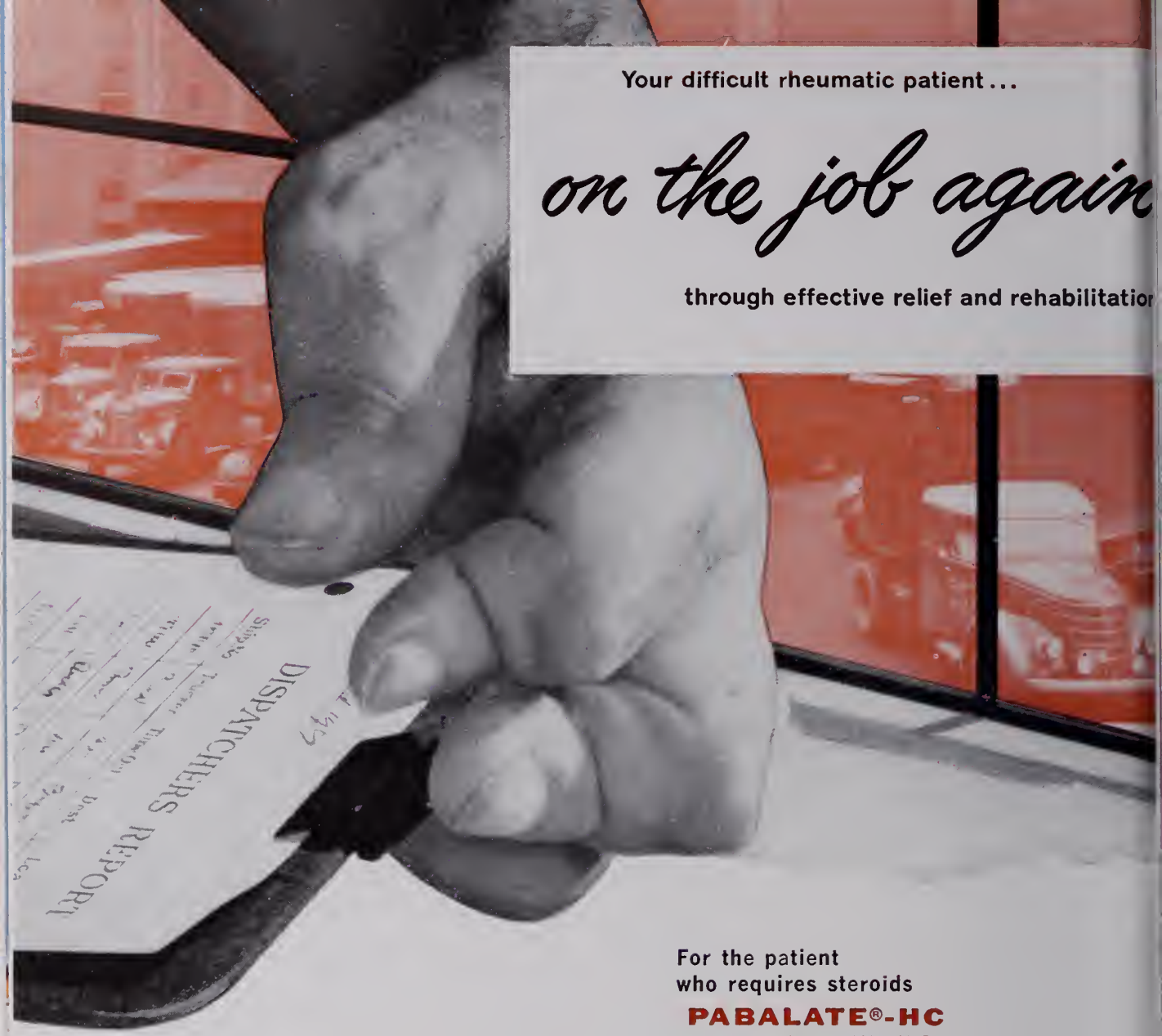
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NEWS ITEMS

Douglas David, M.D., was a member of the panel discussing "Pulmonary Emphysema" at a meeting of the Mississippi Valley Trudeau Society at the St. Nicholas Hotel, Springfield, Ill., on October 9. Doctor David is director of the Cardiopulmonary Laboratory at St. Joseph Infirmary, Louisville.

Robert H. Shipp, M. D., has begun the general practice of medicine and anesthesia in Shelbyville, in association with Donald Chatham, M. D. A native of Louisville, Doctor Shipp received his medical degree from the University of Tennessee in 1958 and interned at the Baptist Hospital in Nashville. He served two years, 1944-46, in the V-12 and Officers Training Programs of the U. S. Navy.

Louis Hamman, M.D., director of the Cumberland Valley Medical Group, was named chief surgeon at the Lynch Notre Dame Hospital upon retirement of Leland E. Payton, M.D., recipient of KSMA's 1959 Outstanding General Practitioner Award. Doctor Hamman, a native of Baltimore, is a graduate of Yale University and Johns Hopkins Hospital. He served in the U. S. Navy during World War II, practiced surgery in Lexington and became head of the Cumberland Valley Group in 1954. He is a member of the KSMA and AMA and a Diplomate of the American Board of Surgery.

David D. Drye, M.D., who practiced at Bradfordsville the past five years, has taken a position as physician at a General Motors plant in Detroit, where he will also do research. A native of Bradfordsville, Doctor Drye was graduated from the University of Louisville School of Medicine in 1953. He interned at General Hospital, Montreal, Canada, and was resident physician at University Hospital, Cleveland, for several months. Doctor Drye is a past president of the Marion-Washington County Medical Society and was named Bradfordsville's Man of the Year in 1956.

Daniel G. Lareau, M.D., has joined the Henderson Clinic in Henderson as an internist, after two years' practice at Gallipolis, Ohio. A graduate of the University of Vermont Medical School, Doctor Lareau interned at the Mary Fletcher Hospital, Burlington, Vt., and served residencies at the VA Hospital, Nashville, and DeGoesbriand Hospital, Burlington. Later he was an associate in the Department of Experimental Medicine at the University of Vermont.

P. O. Lewis, Sr., M.D., of Evarts was honored recently by the Evarts High School in a ceremony at the Evarts-Cumberland football game. The Saturday of the game was designated as "Dr. P. O. Lewis, Sr., Day." A physician in Evarts since 1920, Doctor Lewis is also a community leader. He paved the way for the present football field and was president of the Booster Club in 1948 when it raised about $7,000 for the sports program.

H. William Fister, M.D., has opened an office in the Heyburn Building, Louisville, with practice limited to general surgery and neoplastic diseases. He previously practiced in Waterbury, Conn., 1956-58. Born in Binghamton, N. Y., Doctor Fister was graduated from Harvard Medical School in 1947. He interned at Albany Hospital, Albany, N. Y., and served residencies at the Hospital for Special Surgery and Memorial Cancer Center, New York. He is a Diplomate of the American Board of Surgery. Doctor Fister was a captain in the U. S. Air Force in which he served two years, 1951-53.

Edwin T. Davis, M.D., has opened an office at 1501 Broadway, Paducah, specializing in pediatrics. Born in Paducah in 1927, Doctor Davis was graduated from St. Louis University in 1956, and served his internship at St. John's Hospital, St. Louis, and a residency at Cardinal Glennon Memorial Hospital for Children, that city. He spent two years, 1946-48, in the U. S. Army, attaining the rank of second lieutenant.

Herbert Chaney, M.D., has joined James A. Freeman, M. D., in the general practice of medicine in Dawson Springs. Born in Pike County, Doctor Chaney was graduated from the University of Louisville School of Medicine in 1956 and served his internship at Mercy Hospital, Springfield, Ohio. His military service includes two years as a captain in the U. S. Air Force.

James W. Ramey, M.D., has started the general practice of medicine in Danville. A graduate of Duke Univeristy School of Medicine, Doctor Ramey is a native of Mt. Sterling. He interned at Denver General Hospital in Colorado and was formerly in general practice in Bluefield, West Virginia. He served two years in the Air Force as general medical officer with the rank of Captain.

Madisonville Seminar Draws 35

Some 35 physicians were in Madisonville on October 14 for the fifth Postgraduate Seminar sponsored by KSMA's First, Second and Third Councilor Districts, the Kentucky Academy of General Practice and the Kentucky Tuberculosis Hospital Commission.

The scientific program was presented by Albert B. Dickey, M. D., Madisonville, director of District One State TB Hospital, where the symposium was held, according to Hugh L. Houston, M.D., Murray, First District Councilor.

Apothecary Founder Dies

Samuel Porter Jones, Sr., president and founder of Jones Apothecaries, died of a stroke on October 18 at St. Anthony Hospital. He was 76. Mr. Jones started his first Louisville apothecary in the Francis Building in 1921 and lived to see the business expand to five branches. His work in the field of prescription medicine was honored by national medical organizations.

Student AMA

Chief among the assets which a physician must possess, and certainly that for which he attended medical school, is a knowledge of medicine — that is to say, the accumulation of the facts and practical concepts necessary for the practice of his profession.

No effort is spared in allowing the medical student to obtain a knowledge of medicine in its widest variety and greatest detail. This knowledge he absorbs and he graduates to become a doctor, possessing a great deal of skill and ability.

But how is the knowledge to be obtained by the student, and how is it to be applied so that it may eventually be of the greatest use to the patient? The Apostle Paul says: ". . . and though I have all knowledge . . . and have not love, I am nothing."*

This is the paradoxical situation in which the medical student finds himself. His ultimate use of the great amount of knowledge obtained while in medical school will profit him little if he fails to apply it to his patients because he has an interest in their well being. His concern must be real and not just an ideal.

Most students possess this interest and concern, else they would not have chosen medicine as a profession. It is their task to maintain this basic part of their character and cultivate its use when dealing with people, especially their patients.

To look at it in another way, one might say that the student prepares his mind and his heart for the time when he will become a physician. His mind is made firm and strong with knowledge and his heart is touched with concern and feeling for those who are physically, and oftentimes mentally and spiritually, ill. In short, a medical student is a person who is developing a hard mind and a soft heart.

If he is to be an asset to his profession, his practice, and to himself, the student must learn quickly to integrate these two concepts.

The hard mind is the end product of work and effort, but the soft heart is an attribute of those who have a sincere interest in people and often is not easily achieved. Nevertheless, it is an attribute worth the effort to obtain, for oftentimes it is the distinguishing feature between the bad and good physician.

Olson Huff
Secretary-Treasurer
U. of L. Chapter, SAMA

1 Corinthians 13, Verse 2.

Arthritis Fund Goal Is $72,000

The Arthritis and Rheumatism Foundation opened its fund drive on November 1, with the Kentucky goal set at $72,000. The campaign continues through November 15.

Leaders in the drive in Kentucky are Harold Rosen, general chairman; Mrs. John W. Leake, head of the women's division, and Harold E. Harter, chairman of the special-gifts committee.

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Veterans Administration Outlines Procedure For Receiving Fee-Basis Medical Treatment*

Approximately two years ago the VA changed its treatment authorization procedure. Up to that time, authorizations were renewed every 30 days. Believing that treatment needs of many patients could be predicted for periods longer than 30 days, the Regional Office outpatient activities were allowed to decide in each instance if a patient should be authorized for periods of time up to a year in length. This was the beginning of the "Long Term" authorization.

During the past two years the Clinics changed a large number of patients from "Short" to "Long-Term Authorizations." This has been the experience throughout the United States. As a result, the VA Central Office has ordered a procedure change whereby virtually every fee-treatment patient will be authorized treatment on a "Long-Term" basis.

Beginning July 1, 1959, with few exceptions, the authorizations received by physicians will remain effective from the month in which the authorization was issued until June 30, 1960. Contained thereon will be a statement defining the extent of medical service it is reasonable to assume will be required by the patient during the period of time covered by the authorization.

Renewal Request Not Required

Physicians need not request renewal of their authorizations during this period, nor must they obtain additional authorization if they find minor deviation from the treatment plan to be necessary. Unless an authorization contains a limitation, the VA will expect to hear from the physician only if he determines that the veteran's needs for treatment are at great variance from the service authorized. In that event, the existing authorization will be cancelled and one better suited to the patient's requirements provided.

A physician who dispenses drugs or biologicals will include them in his established visit fee when the drugs are routine non-expensive items. When an expensive drug is required, it is suggested that he forward his prescriptions to the Veterans Administration Regional Office Pharmacy or to a local pharmacy, participating in the State pharmaceutical plan. It is understood that physicians may prescribe all drugs, expensive and non-expensive. If they dispense expensive drugs, the charge to the Veterans Administration should not exceed the cost of the drugs to them.

Together with the authorization, physicians will receive preheaded forms identifying both him and the patient. One of these forms is entitled "Report of Outpatient Treatment," and the other "Statement of Account for Medical Services." On the one he will report treatment rendered, submitting the form at the end of each calendar month during which he treated the patient. On the other he prepares his statement of charges, submitting this form with his report of outpatient treatment.

Forms Replaced Each Time

These two forms will be replaced each time he has occasion to use them, and they will always be in a preheaded manner, requiring the entry of his report or bill, and signature, for completion.

The authorization form, VA Form 10-7080, printed on green paper stock, will be used exclusively to authorize outpatient treatment. This form also will be used when occasion demands authorization of treatment for short durations, such as a three-month course of deep X-ray therapy, a specified number of allergy tests, etc. In these instances, reports of treatment and bills will not be expected until after the conclusion of the short courses of treatment.

Physicians may occasionally receive an authorization on VA Form 10-7079, printed on white paper stock. The format is similar to the treatment authorization form. The purpose of this white form is to authorize examination rather than treatment. The form, or forms, which he receives with an examination authorization will be special ones suited to reporting the examination results. In addition to the authorization and special report forms, the physician will receive a "Statement of Account" on which he submits his bill.

Procedures Simplified

It is believed we are nearing the ultimate of simplicity of procedures in the authorization of fee treatment by placing in the physician's hands a single authorization which provides coverage for both the patient and physician for periods as long as twelve months.

Physicians should read the instructions which appear on the reverse of each authorization. These instructions will help them understand this new procedure. If a physician receives an authorization which leaves him in doubt as to how to proceed, he should not hesitate to contact the Director, Outpatient Clinic, VA Regional Office, Louisville, Kentucky.

**Submitted by O. P. Miller, M.D., Director, Outpatient Clinic, Veterans Administration Regional Office, 1405 West Broadway, Louisville.*

Dr. Howard of Glasgow Honored

The surprise unveiling of a portrait of C. C. Howard, M.D., was a feature of the program of open house at the T. B. Hospital in Glasgow on October 5. The picture hangs in Howard Hall of the Glasgow Practical Nurses Home.

Doctor Howard is a past president of the Kentucky State Medical Association and past chairman of the Council. He is presently chairman of the Rural Kentucky Medical Scholarship Fund and chairman of the State T. B. Committee.

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reduces pain in angina pectoris

NIAMID, in intensive clinical tests, has proved to have a high degree of safety and to be a valuable adjunct in the management of the anginal syndrome. NIAMID produces striking symptomatic improvement in angina patients...

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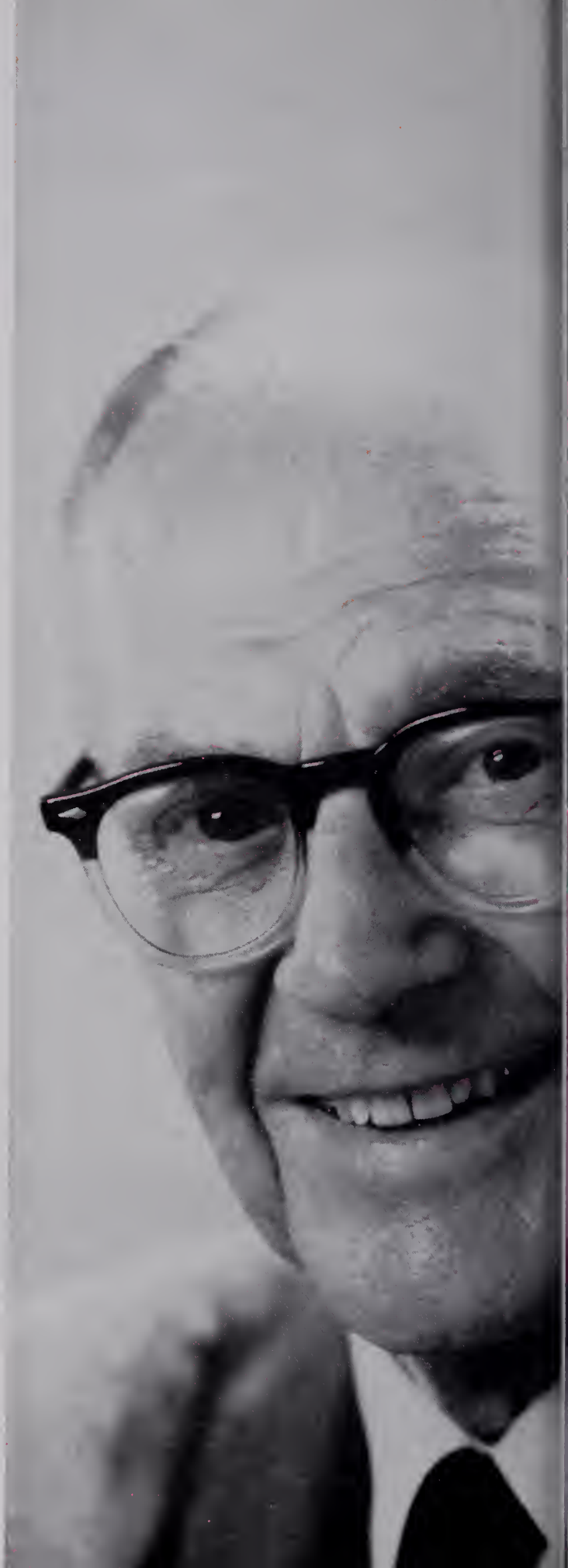
Note: Because of dramatic relief of symptoms and increased sense of well-being in anginal cases, it is advisable to caution the patient against overexertion.

DOSAGE: Start with 75 mg. of NIAMID daily in single or divided doses. After 2 weeks or more, adjust the dosage, depending upon patient response, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to the maintenance level. Many patients respond to NIAMID within a few days, others within 7 to 14 days. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

A Professional Information Booklet giving detailed information on NIAMID *is available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

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In Memoriam

AUSTIN L. BECKETT, M. D.

Lexington
1882-1959

Austin L. Beckett, M. D., clinical director of Eastern State Hospital, died on September 10 at St. Joseph Hospital, Lexington, after a long illness. He was 77 years old.

A 1907 graduate of the University of Louisville School of Medicine, Doctor Beckett practiced in Campbell County for many years before taking the hospital post. He was a member of the Southern Psychiatric Association and the Fayette County Medical Society.

PHILIP H. DORGER, M. D.

Covington
1885-1959

Philip Henry Dorger, M. D., general practitioner in Covington for a half century, died at his home on September 18 at the age of 74. He retired in May, 1957, because of illness.

A native of Cincinnati, Doctor Dorger was graduated from Ohio Medical Institute in 1909. He started the practice of medicine in Cincinnati, moving to Covington soon thereafter. He served in the Army Medical Corps during World War I.

FRANK H. SMITH, M. D.

Paint Lick
1883-1959

Frank Harmon Smith, M. D., a physician at Paint Lick for 44 years, died at Good Samaritan Hospital, Lexington, on October 6. He was 76 years old.

Born in Harlan County on September 14, 1883, Doctor Smith was graduated from the University of Louisville School of Medicine in 1913. He was a member of the Kentucky State Medical Association and a past president of the Madison County Medical Society.

EDWARD L. KENNEDY, M. D.

Smithland
1876-1959

Edward L. Kennedy, M. D., a practicing physician for 59 years, died on October 6 at his home in Smithland, where he had maintained an office since 1937. At 83, he was one of Western Kentucky's oldest practicing physicians.

Doctor Kennedy was a native of Marshall County. A 1900 graduate of the University of Tennessee Medical School, he practiced in Tennessee, Arkansas and Kentucky. He moved to Smithland from Tiline, Livingston County, after the flood. Doctor Kennedy was a member of the Kentucky State Medical Association.

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Let's Not Be Sold Out

(Continued from Page 1388)

Our KSMA Legislative Committee has done a splendid piece of work in setting up procedures to make the influence of medicine felt both in Washington and in Frankfort. Many of you are a part of this procedure. All of you will have an opportunity to resist Forand-type legislation when it is again considered next spring. We hope that you will discharge your obligation to your profession and to your patients in this field as diligently as you do in looking after their medical problems. If you will do this, there will be no doubt about the outcome.

Medicine Can Lose Only Once

In speaking of outcomes, we should like to emphasize this point. Proponents of Forand-type legislation can lose, and lose, and lose again; but if medicine loses, that is the end. That is it.

One of organized medicine's all-time greats is the late Irvin Abell, Sr., M.D., father of our President-Elect. He was a man of great wisdom and foresight and most interested in the welfare of the people and of medicine. I recall hearing him say in 1937 at our Annual Meeting in Richmond, *"medicine will not be socialized unless those practicing the healing arts are sold out, or give their consent."*

Let's not forget these splendid words from Doctor Abell. Let's not be sold out; and certainly the only way that we could consent would be through failure to discharge our obligation as physicians.

A physician to practice on Smith Island, in Chesapeake Bay, Maryland, is being sought by Edward W. Crandall, LCDR, U. S. Naval Reserve, Retired, who recently visited the island and learned of its need of medical care. The physician who takes the post would occupy a new house which the Islanders, recognizing the seriousness of being without a doctor, built at their own expense. For further information, contact Commander Crandall, P. O. Box 163, Louisville 7, Ky.; phone, TW 3-3840.

"Radiation: Fact Versus Fear" was the subject of an address by Dr. Harrison M. Berry, Philadelphia dentist, before a dinner meeting of the Louisville District Dental Society at the Brown Hotel on October 15. Doctor Berry, president-elect of the American Academy of Oral Rosentgenology, is professor of radiology at the University of Pennsylvania Dental School.

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JOHN D. PATTON, M.D.
Clinical Director

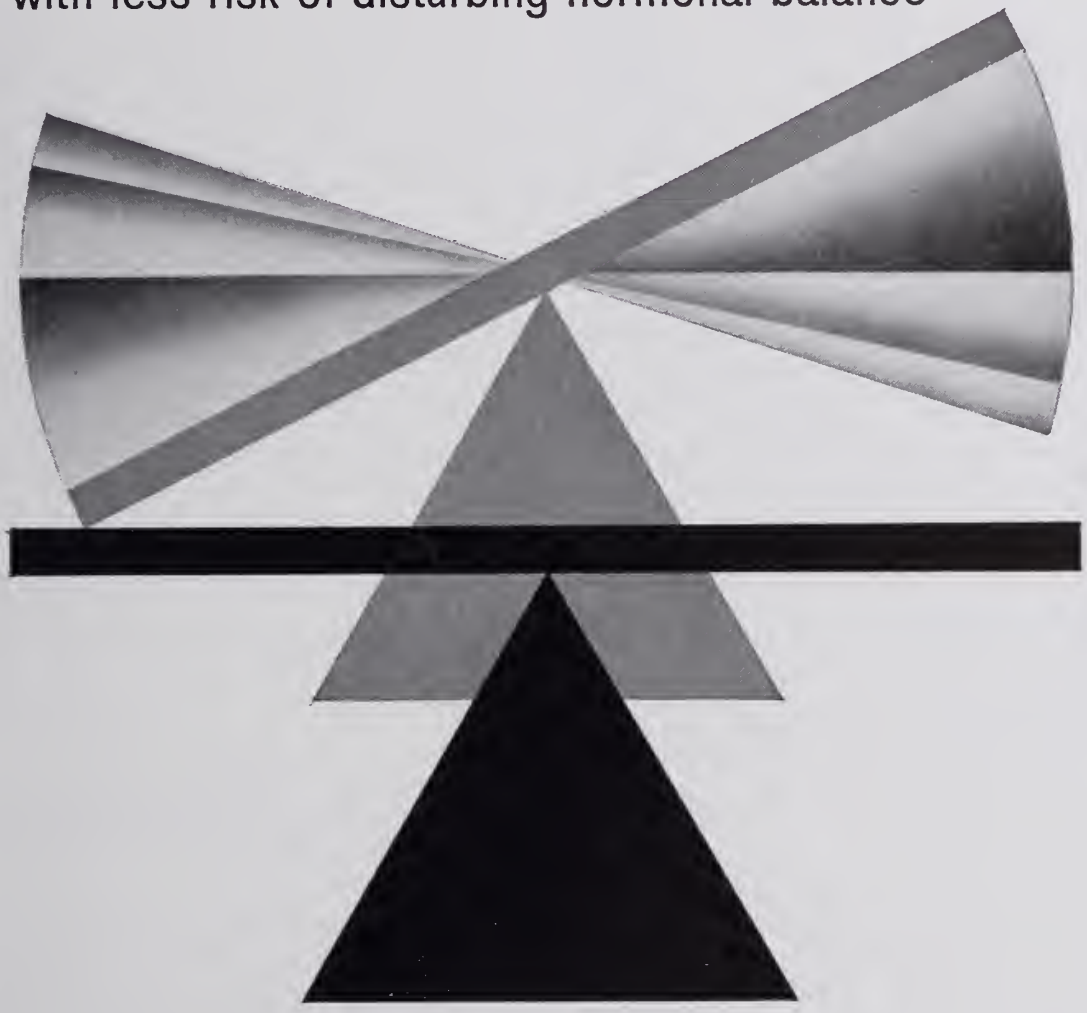
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1. Kuzell, W. C., and others.: Arch. Int. Med. 92:646, 1953. 2. Wolfson, W. Q.: J. Michigan M. Soc. 54:323, 1955. 3. Strandberg, B.: Brit. J. Phys. Med. 19:9, 1956. 4. Platt, W. D., Jr., and Steinberg, I. H.: New England J. Med. 256:823 (May 2) 1957.

Geigy, Ardsley, New York

03859



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



CASE # 41: This patient was a 33-year-old married white gravida 2, para. 1 who had no prenatal care and was delivered as a clinic patient. Nothing was known of her first delivery except the child was living. She was at term when admitted. The doctor who attended her saw her initially when she was on the way to the delivery room. Her contractions were every 2-3 minutes. She went straight to the delivery room after admission and was anesthetized at once with cyclopropane.

Vaginal examination revealed cephalic presentation, ROP. An attempt was made to rotate the head through 135°, but it couldn't be maintained while the forceps were reapplied. The rotation was repeated two more times only to have the head rotate back ROP. No mention was made of the type of forceps used nor of the type rotation executed.

It was then felt additional anesthesia would be hazardous to both mother and infant, so the infant was delivered as a posterior with the aid of a generous RML episiotomy. It was described as a hard pull, with the episiotomy tearing to but not extending into the rectum. The first stage of labor was given as 3 hours; the patient received 25 mg phenergan, 1/150 gr atropine and 50 mg Demerol at 10:00 AM and delivered at 10:50 AM, 5-14-58, a 7 pound, 11 ounce infant girl who breathed immediately. There were no misplaced forceps marks.

During repair of the episiotomy and tear the patient went into shock. Blood and levophed were ordered and consultation was requested. There appeared to be only minimal blood loss, but nothing was known of her prenatal count. Her blood pressure came back up with the blood being pumped in. She was reacting in the recovery room and her blood pressure was normal when she received an estimated 50-60 cc of air intravenously when the blood ran in before the tubing was clamped off. The patient immediately stiffened; cardiac arrest followed.

At the same time the consultant arrived. Cardiac massage and defibrillation was instituted after approximately 30 cc of air was aspirated from the heart. Massage was done twice more each time opening the chest again. An endotracheal tube was in place when the chest was opened or shortly thereafter. In spite of these procedures the patient died about 4 hours postpartum. Autopsy revealed approximately 30 cc free air in the right ventricle plus air bubbles in the coronary arteries.

There was also discovered an intrapelvic hematoma of approximately 500 cc blood localized anterior to the bladder and dissecting out toward the round ligaments. The attending physician thought this was not a result of the forceps, but resulted from the traction in delivering the infant as an ROP.

The cause of death on the certificate was: Air embolism with cardiac arrest with pelvic hematoma and shock.

Comment

The committee considered this a preventable obstetrical death with the cause as given on the death certificate correct.

It was agreed this fatality could have been avoided had a double bottle set-up been used for the blood transfusion or the blood been in a plastic bag which would have collapsed when empty. This should always be done if it is necessary to give fluids under pressure.

The physician was also responsible in that had the laceration not been sustained the patient would not have needed the transfusion. There was no apparent reason for immediate delivery and a longer second stage might well have accomplished spontaneous rotation. The committee felt the laceration was a result of the unsuccessful rotation.

Again this case clearly demonstrated the importance of an autopsy to determine the underlying cause of death.

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Bagnall, A. W. (Univ. British Columbia, Vancouver, B.C.): A.M.A. Clinical Meeting (Scientific Section, Exhibit No. 124), Minneapolis, Minnesota, Dec. 2-5, 1958.

"The 4-aminoquinoline drugs (Plaquenil and Aralen) together with supplemental agents administered in nontoxic doses effectively maintained suppression of the disease in 83 per cent of 194 patients followed for 18 months."

Scherbel, A. L.; Harrison, J. W., and Atdjian, Martin: Cleveland Clin. Quart. *25:95, April, 1958.*

"When used in tolerated dosage and over a sufficient period of time, there appears to be a tremendous therapeutic potential in the antimalarial drugs. . . . Plaquenil in this study did not have as many side effects as Aralen and thus appears to be a more practical compound."

Cramer, Quentin (Kansas City): Missouri Med. *55:1203, Nov., 1958.*

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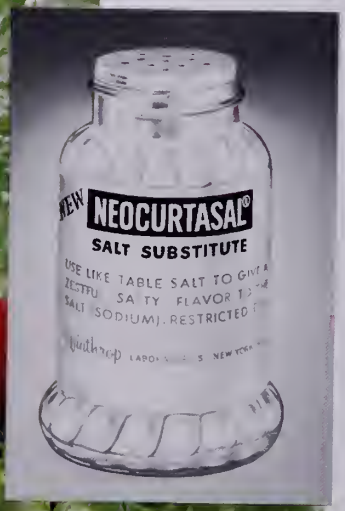
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BONADOXIN®
tablet stops morning sickness (you take it at bedtime)"



The formula tells why BONADOXIN quickly stops nausea and vomiting of pregnancy in 9 out of 10 cases.* Each tiny BONADOXIN tablet contains: Meclizine HCl (25 mg.) for antinauseant action / Pyridoxine HCl (50 mg.) for metabolic replacement

More than 60,000,000 tablets prescribed and taken. Toxicity low, tolerance excellent. In bottles of 25 and 100. Usual dose: one tablet at bedtime; severe cases may require another on arising. See PDR, p. 779.

BONADOXIN also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, cerebral arteriosclerosis and motion sickness.

After Baby Comes

For infant colic, try antispasmodic BONADOXIN Drops... stop colic in 7 out of 8 cases.*

Each cc. contains:
Meclizine 8.33 mg. / Pyridoxine 16.67 mg.

See PDR, p. 779.

*Bibliography available on request.

Roerig *New York 17, New York · Division, Chas. Pfizer & Co., Inc. · Science for the World's Well-Being*

1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the efficacy, potency and purity of Bayer Aspirin, the world's first aspirin.

And the same manufacturing skill, the same 106 ingredient and product tests, the same exclusive processes which contribute to the superiority of Bayer Aspirin set the standards of excellence for Bayer Aspirin for Children.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

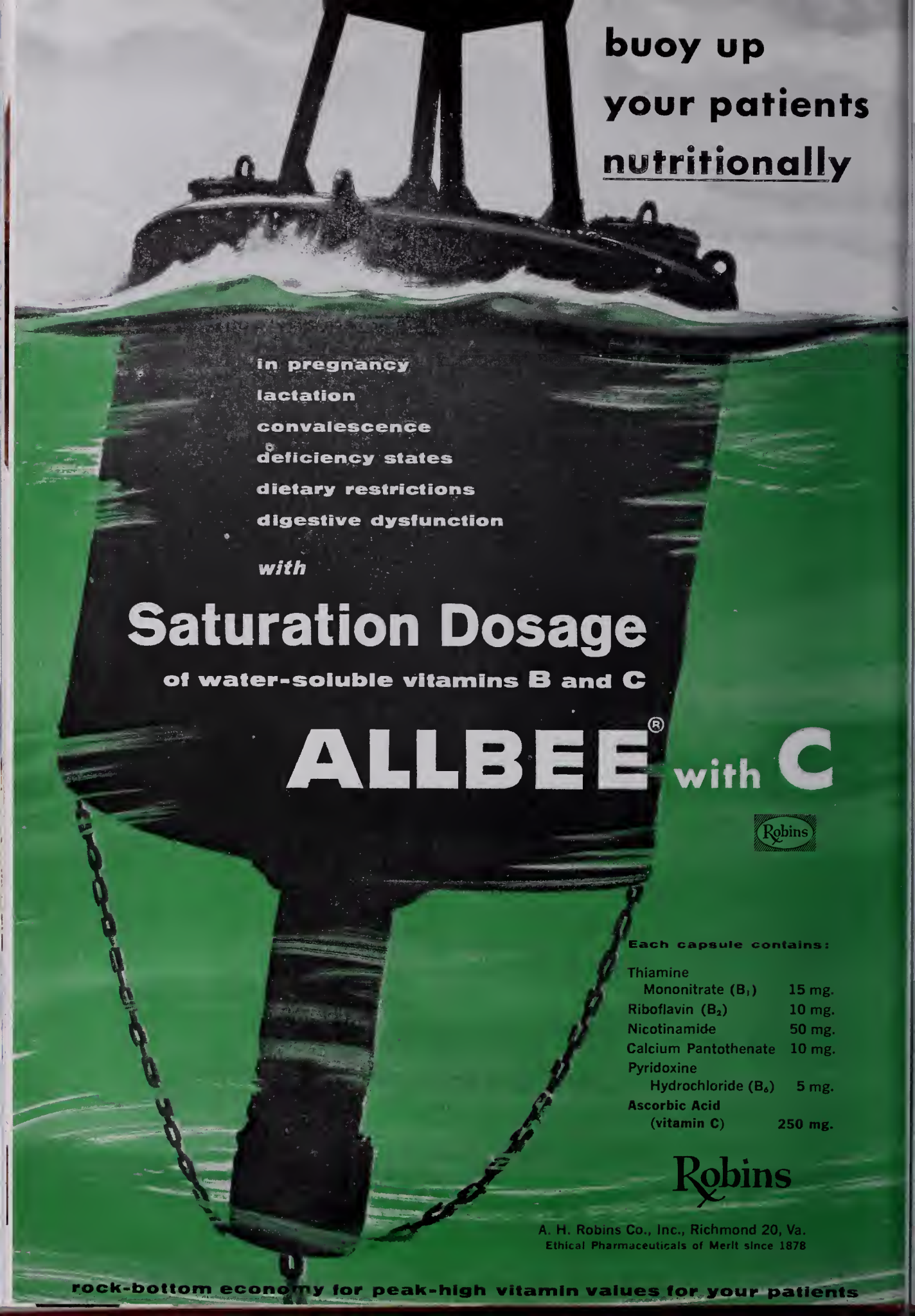
Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New Tamper-Proof Cap



THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.


buoy up
your patients
nutritionally
in pregnancy
lactation
convalescence
deficiency states
dietary restrictions
digestive dysfunction
with
Saturation Dosage
of water-soluble vitamins B and C
ALLBEE® with C
Robins
Each capsule contains:
Thiamine Mononitrate (B_1) 15 mg.
Riboflavin (B_2) 10 mg.
Nicotinamide 50 mg.
Calcium Pantothenate 10 mg.
Pyridoxine Hydrochloride (B_6) 5 mg.
Ascorbic Acid (vitamin C) 250 mg.
Robins
A. H. Robins Co., Inc., Richmond 20, Va.
Ethical Pharmaceuticals of Merit since 1878
rock-bottom economy for peak-high vitamin values for your patients



HEARING, A HANDBOOK FOR LAYMEN: by Norton Canfield, M.D., published by Doubleday & Company, Garden City, N.Y., 1959; 214 pages; price, $3.50.

SUMMARY: Norton Canfield, a national consultant on hearing, discusses in clear detail the problem — medical, psychological, economic and social — of the hearing handicapped.

This book is written in plain, nontechnical, easily-understandable language to aid the nearly seventeen million Americans suffering from some form of impaired hearing. Every aspect of impaired hearing, its causes, types and treatment, as well as the psychological and economic problems, are discussed in practical detail.

Doctor Canfield begins with a brief medical discussion of the various degrees and types of deafness and then outlines in practical detail the many treatments available. How to detect a hearing handicap in a child; how to begin treatment and therapy; the modern surgical procedures which can cure or relieve impaired hearing; the latest advances in hearing aids and the remarkable work carried on in hearing rehabilitation centers. These and many other important questions are discussed in this sympathetic and comprehensive handbook.

If more were done for those with hearing loss, their social and economic contributions would add to the happiness of all. Proper evaluation of the hearing capacity is the first step. Then each person should receive the proper rehabilitation assistance that has already helped countless others.

Although published primarily as a guide for laymen, this book has an important message to doctors, nurses, teachers and all who at some time will come in contact with a hearing problem.

R. Glen Boles, M. D.

THE MANAGEMENT OF FRACTURES AND DISLOCATIONS, An Atlas, Volumes I and II: by Anthony F. DePalma, M.D.; published by W. B. Saunders Company, Philadelphia, January, 1959; Vol. I, 470 pages; Vol. II, 490 pages; price, $35.

This two-volume atlas is almost anyone's answer to the need for a ready and quick reference for the treatment of any specific fracture. The author has simply outlined the important facts in the management of any dislocation or fracture, and has placed it in a plain and abbreviated text.

Each fracture and disclocation is illustrated with pen line sketches, which demonstrate step by step the setting, management and after-care of fractures. All fractures and dislocations are clearly described, pathology illustrated and end results explained.

Each fracture is treated separately in the text on through the phase of rehabilitation.

This volume is especially valuable for the inexperienced who can quickly find the methods of reducing the individual fractures and dislocations with the type of cast and immobilization which is necessary. The surgeon who treats occasional fractures should have these volumes at hand for guidance. For hospitals with resident training programs in surgery or orthopaedic surgery, the atlas is a quick and ready reference with the latest and most acceptable methods of treatment.

K. Armand Fischer, M.D.

A DOCTOR REMEMBERS: by Edward H. Richardson, M. D.; published by the Vantage Press, New York, 1959; 252 pages; price, $3.95.

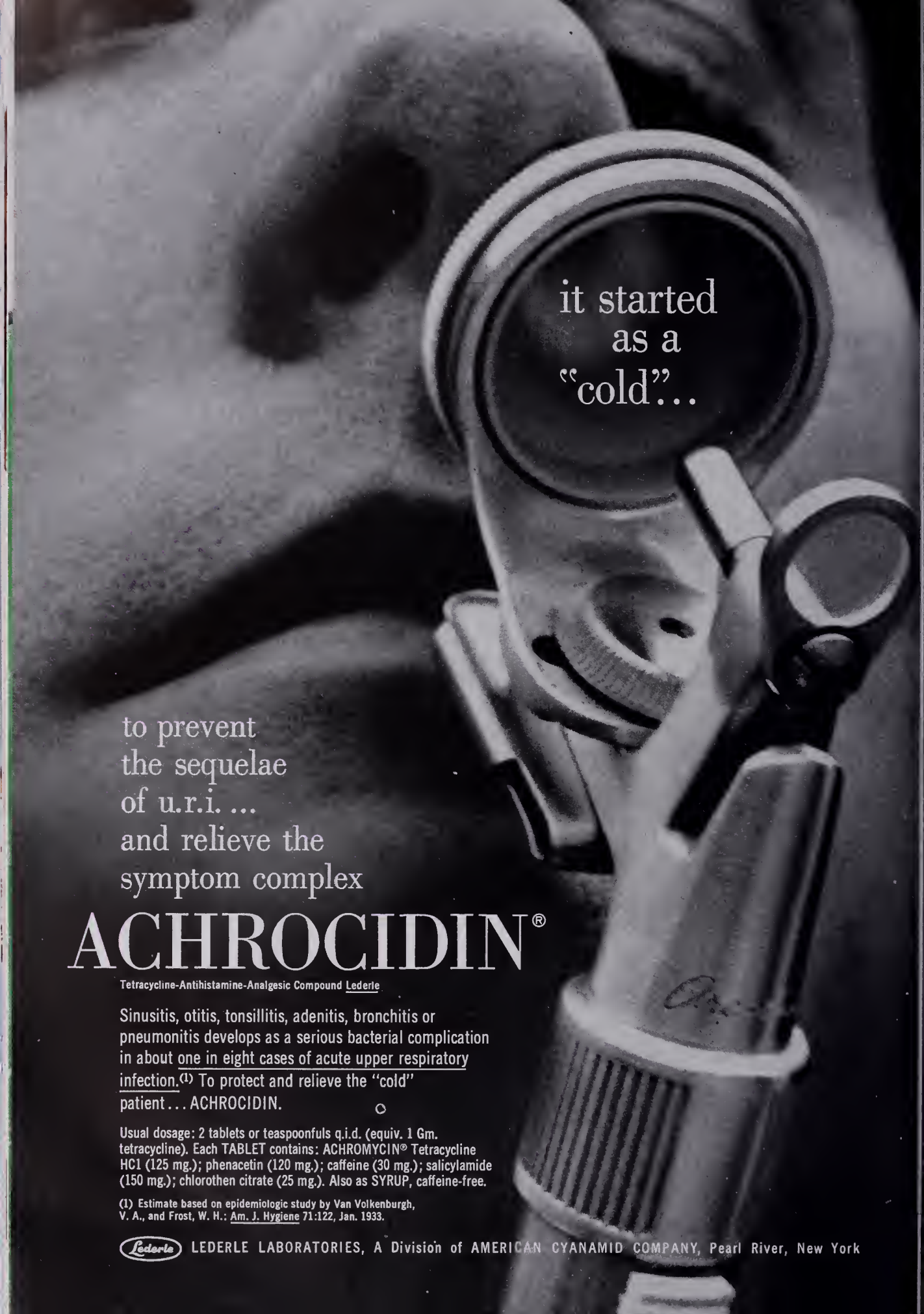
A Doctor Remembers comprises selected personal experiences and sober reflections of a recently retired, leading gynecologic surgeon of Baltimore. Doctor Edward H. Richardson at 80 today belies his years, and is a handsome, courteous gentleman of the old Southern school (he was born in Farmington, Virginia).

He comments, with much humor in many Southern stories, on various periods of his life, including boyhood, lower school, college, medical school, residency training, and finally a long and successful practice in gynecologic surgery. His remembrance of associations with Welch, Osler, Halsted, and Kelly gives insight into the character of these men not found elsewhere.

A striking feature of the book is the expression of his convictions regarding the full-time principle in medical schools. Full-time professors in medicine, surgery, and pediatrics were appointed at the Johns Hopkins, beginning in 1914. Gradually, more departments have been made full-time.

"It now appears to this alumnus that, at long last, the fulltime experiment as originally conceived by its sponsors has been thoroughly tested for 43 years, and found under existing conditions to be impractical and unworkable." Richardson certainly presents this material in a forceful manner. "It is highly probable that . . . (these convictions) . . . will arrest and hold the attention of the full-time devotees only long

(Continued on Page 1426)



to prevent
the sequelae
of u.r.i. ...
and relieve the
symptom complex

ACHROCIDIN®

Tetracycline-Antihistamine-Analgesic Compound Lederle

Sinusitis, otitis, tonsillitis, adenitis, bronchitis or pneumonitis develops as a serious bacterial complication in about one in eight cases of acute upper respiratory infection.(1) To protect and relieve the "cold" patient... ACHROCIDIN.

Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York



running noses and open stuffed noses orally



Triaminic®

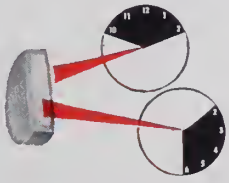
the leading oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract.

safer and more effective than topical medication[1,2,3]

- systemic transport to all respiratory membranes
- provides longer-lasting relief
- presents no problem of rebound congestion
- avoids "nose drop addiction"

Relief with Triaminic is prompt and prolonged because of this special timed-release action . . . beneficial effect starts in minutes, lasts for hours



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each TRIAMINIC Tablet provides:
Phenylpropanolamine HCl .....50 mg.
Pheniramine maleate .....25 mg.
Pyrilamine maleate .....25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to ¼ of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

immortals of chinese mythology:



Lu Tung-pin

This scholarly but fierce mystic earned his place in the Taoist pantheon by slaying dragons with a magic sword

...this experience-tested steroid has earned its place in twentieth-century medicine by its unsurpassed results in acute and chronic steroid-responsive disorders

METICORTEN

METICORTEN,® brand of prednisone, 5 mg. tablets.

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

You will soon receive in your mail a full-color, handmade, three-dimensional figure of this Chinese Immortal, mounted and suitable for framing.

9-222

Schering

IN THE BOOKS

(Continued from Page 1423)

enough for them to be mildly amused by the feeble but frisky cavortings of an old war horse who now and again still senses the smell of battle smoke..."

Aside from this stand that is controversial, the author deals entirely with his pleasant and productive life, and makes observations on medical practice and human beings. He states his greatest satisfaction has been his teaching and training of medical students and post-graduate members of house staffs. His two original operative procedures are widely known: the Richardson abdominal total hysterectomy, and the composite operation for uterine prolapse (the Spalding-Richardson operation).

Recently TeLinde has said, "Richardson taught me most of my operative gynecology. Technically he was the best surgeon on the staff here."

It is a pleasure to read of the life and observations of one of the great surgeons of our time.

Laman A. Gray, M. D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

CLINICAL AUSCULATION OF THE HEART: by Samuel A. Levine, M. D., Sc.D., (Hon.), F.A.C.P., and W. Proctor Harvey, M. D.; published by W. B. Saunders Company, Philadelphia and London.

MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN: by George S. Stevenson, M. D., and Harry Milt, public relations director, National Association for Mental Health; published by Prentice Hall, Inc., Englewood Cliffs, N. J.

SYPNOSIS OF GYNECOLOGY: by Robert James Crossen, M. D., Daniel Winston Beacham, M. D., and Woodard Davis Beacham, M. D.; published by the C. V. Mosby Company, St. Louis.

CURRENT MEDICAL REFERENCES: edited by Paul J. Sanazaro, M. D.; published by Lange Medical Publications, Los Altos, Calif.

HANDBOOK OF POISONING: DIAGNOSIS AND TREATMENT: by Robert H. Dreisbach, M. D., Ph. D.; published by Lange Medical Publications, Los Atos, Calif.

JEWISH MEDICAL ETHICS: by Imanuel Jakobovits, Rabbi Dr.; published by Philosophical Library, New York.

LIVING BEYOND YOUR HEART ATTACK: by Eugene B. Mozes, M.D.; published by Prentice Hall, Inc., Englewood, N. J.



for the tense and nervous patient

relief comes fast and comfortably

–does not produce autonomic side reactions
–does not impair mental efficiency, motor control, or normal behavior.

Usual Dosage: One or two 400 mg. tablets t.i.d.

Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets or as MEPROTABS*—400 mg. *unmarked*, coated tablets.

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

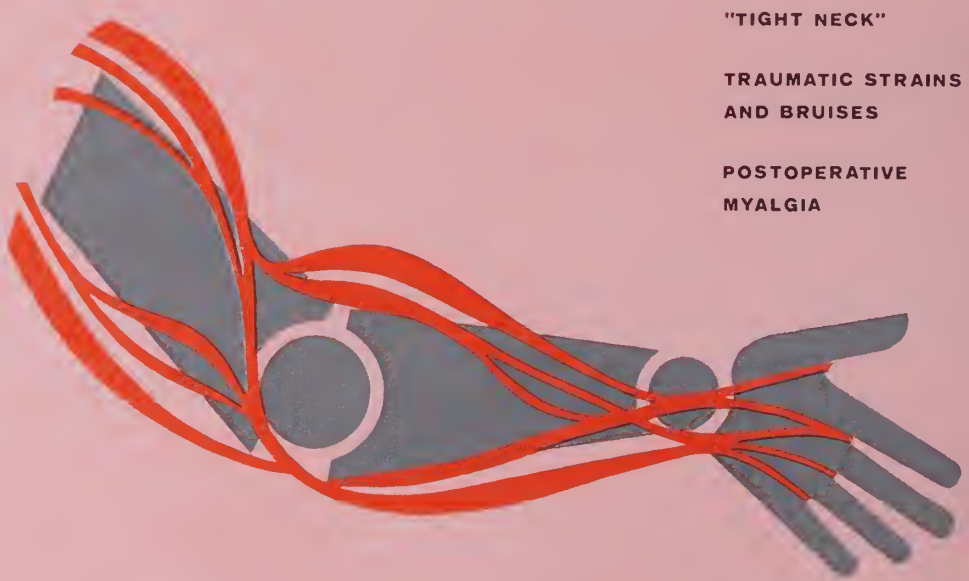
CM-9470

NOW

. . . a new way to relieve pain and stiffness in muscles and joints

indicated in:

- MUSCLE STIFFNESS
- LUMBOSACRAL STRAIN
- SACROILIAC STRAIN
- WHIPLASH INJURY
- BURSITIS
- SPRAINS
- TENOSYNOVITIS
- FIBROSITIS
- FIBROMYOSITIS
- LOW BACK PAIN
- DISC SYNDROME
- SPRAINED BACK
- "TIGHT NECK"
- TRAUMATIC STRAINS AND BRUISES
- POSTOPERATIVE MYALGIA



■ Exhibits unusual analgesic properties, different from those of any other drug ■ Specific and superior in relief of SOMAtic pain ■ Modifies central perception of pain without abolishing natural defense reflexes ■ Relaxes abnormal tension of skeletal muscle

SOMA™

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

■ More specific than salicylates ■ Less drastic than steroids

■ More effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. SOMA is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with SOMA than with previously used analgesic, sedative or relaxant drugs.
SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

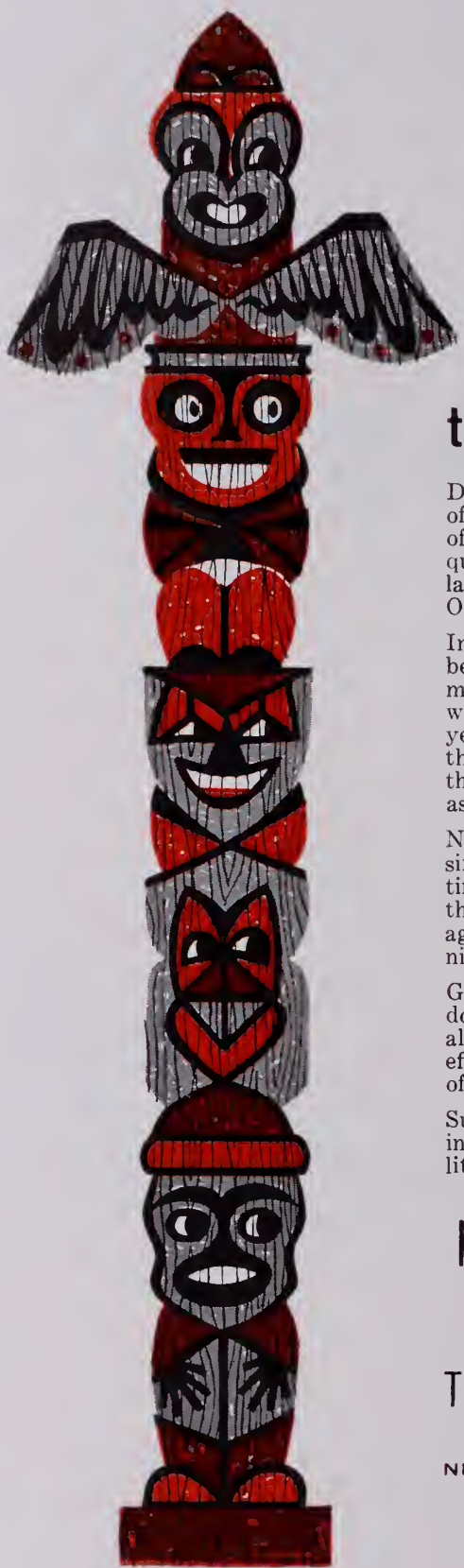
NOTABLY SAFE. Toxicity of SOMA is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy, particularly on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white coated 350 mg. tablets.

Literature and samples on request.

WALLACE LABORATORIES, NEW BRUNSWICK, N. J.



the disease of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is "one of the most widespread and serious protozoan diseases of man," yet "there is no parasite more often misdiagnosed than is *E. histolytica*." Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

new Glarubin

TABLETS

specific for intestinal amebiasis

THE S. E. MASSENGILL COMPANY

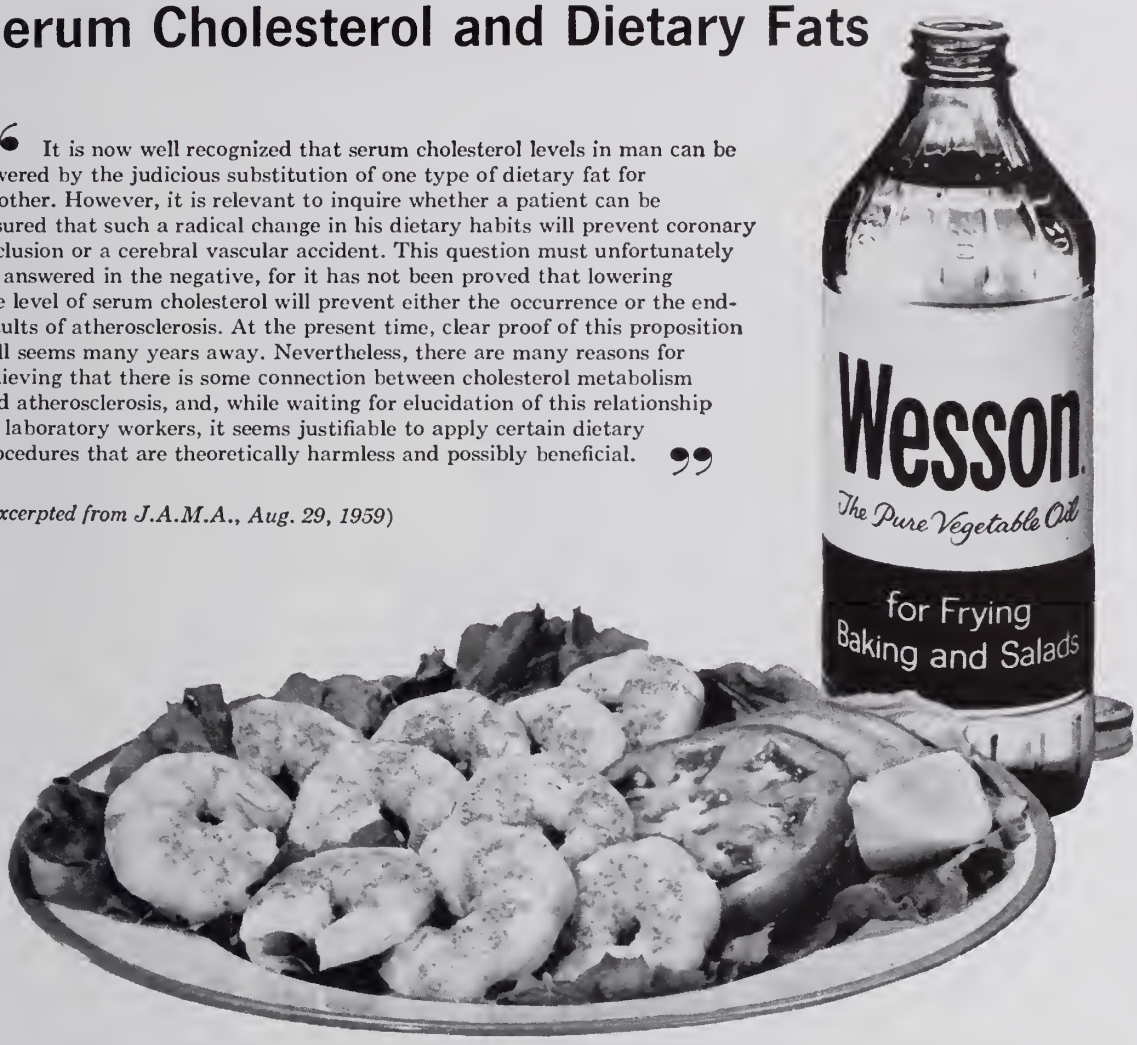
BRISTOL, TENNESSEE

NEW YORK · KANSAS CITY · SAN FRANCISCO

A Significant Statement about Serum Cholesterol and Dietary Fats

"It is now well recognized that serum cholesterol levels in man can be lowered by the judicious substitution of one type of dietary fat for another. However, it is relevant to inquire whether a patient can be assured that such a radical change in his dietary habits will prevent coronary occlusion or a cerebral vascular accident. This question must unfortunately be answered in the negative, for it has not been proved that lowering the level of serum cholesterol will prevent either the occurrence or the end-results of atherosclerosis. At the present time, clear proof of this proposition still seems many years away. Nevertheless, there are many reasons for believing that there is some connection between cholesterol metabolism and atherosclerosis, and, while waiting for elucidation of this relationship by laboratory workers, it seems justifiable to apply certain dietary procedures that are theoretically harmless and possibly beneficial."

(Excerpted from J.A.M.A., Aug. 29, 1959)



Where a poly-unsaturated oil is called for in the diet, Wesson satisfies the most exacting requirements (and the most exacting appetites).

To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson,* particularly by the criteria of odor, flavor (blandness) and lightness of color.

Uniformity you can depend on. Wesson has a *poly*-unsaturated content better than 50%. Only the lightest cottonseed oils of highest iodine number are selected for Wesson, and no significant variations in standards are permitted in the 22 exacting specifications required before bottling.

Each pint contains 437—524 Int. Units of Vitamin E.

Wesson's Important Ingredients:

Linoleic ocid glycerides	50% to 55%
Phytosterol (predominontly beto sitosterol)	0.4% to 0.7%
Totol tocopherols	0.09% to 0.12%

Never hydrogenoted—completely solt free

*Reconfirmed by recent tests against the next leading brand with brand identifications removed, among a national probability sample.

relieve the tension—and control its G.I. sequelae



...Pathibamate®

meprobamate with PATHILON® tridihexethyl chloride Lederle

for relieving tension and curbing hypermotility and excessive secretion in G. I. disorders

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.)—a tranquilizer and muscle-relaxant widely accepted for the effective management of tension and anxiety

PATHILON (25 mg.)—an anticholinergic long noted for producing prompt symptomatic relief through peripheral, atropine-like action, yet with few side effects

now available...

PATHIBAMATE-200 Tablets

200 mg. meprobamate • 25 mg. PATHILON

for more flexible control of G. I. trauma and tension smooth, sugar-coated, easy-to-swallow

PATHIBAMATE-400 and PATHIBAMATE-200 are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Supplied: PATHIBAMATE-400—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

HELP US KEEP THE THINGS WORTH KEEPING



Here's what peace is all about. A world where busy little girls like this can stand, happily absorbed in painting a bright picture that mother can hang in the kitchen and daddy admire when he gets home from work.

A simple thing, peace. And a precious one. But peace is not easy to *keep*, in this troubled world. Peace costs money.

Money for strength to keep the peace. Money for science and education to help make peace lasting. And money saved by individuals to keep our economy sound.

Every U.S. Savings Bond you buy helps provide money for America's Peace Power—the power that helps us keep the things worth keeping.

Are you buying as many as you *might!*

HELP STRENGTHEN AMERICA'S PEACE POWER

BUY U. S. SAVINGS BONDS

The U.S. Government does not pay for this advertising. The Treasury Department thanks The Advertising Council and this magazine for their patriotic donation.



when upper respiratory congestion is complicated by bacterial invaders

TRISULFAMINIC provides logical therapy

- for the patient ill with congestion and infection of the upper respiratory tract, as in purulent rhinitis, sinusitis, tonsillitis and otitis media, when caused by sulfa-susceptible bacteria;
- because secondary invasion by such bacteria so frequently follows the common cold.[1]

the reasons for combining Triaminic with triple sulfas

Triaminic and triple sulfas are not only pharmacologically *compatible*, they are a therapeutically *logical* combination for upper respiratory infections: Triaminic for effective decongestant relief from rhinitis, rhinorrhea and sinusitis;[2] triple sulfas for well-established antibacterial action.

The advantages of Trisulfaminic in upper respiratory infections include: proved effectiveness; safety; economy; ease of administration; less likelihood of sensitivity reactions;[3] compatibility with antibiotics and other antibacterial therapy. Provided also as Suspension for additional convenience.

Trisulfaminic®

TRIAMINIC WITH TRIPLE SULFAS

Available as TABLETS and SUSPENSION

Each easy-to-swallow Trisulfaminic Tablet or 5 ml. teaspoonful of Suspension provides:

Triaminic® .....25 mg.
(phenylpropanolamine HCl 12.5 mg.
pheniramine maleate ..... 6.25 mg.
pyrilamine maleate ..... 6.25 mg.)
Trisulfapyrimidines, U.S.P. .....0.5 Gm.

Dosage:

Adults—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12* — 2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

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CITY VIEW SANITARIUM

Established 1907

NASHVILLE -:- TENNESSEE

For the diagnosis and treatment of
mental and nervous disorders, and
addictions to alcohol and drugs

Psychotherapy and occupational therapy

Electrical shock and insulin therapy as indicated

Frank W. Stevens, M. D.
Director

G. Tivis Graves, Jr., M. D.
Associate Director



For Quality without Question... Enjoy the unique refreshment of sparkling Coca-Cola



SIGN OF GOOD TASTE

Why should I use KANTREX® Injection* when there are so many other antibiotics available?

Because KANTREX Injection is bactericidal to a wide variety of organisms, including many that are highly resistant to the other antibiotics[3,4,10,12,13,17,18,20,21,23,24,25,27,30,33,35,37]

—organisms such as *Staph. aureus*, *Staph. albus*, *A. aerogenes*, *E. coli*, *H. pertussis*, *K. pneumoniae*, *Neisserio* sp., *Shigella*, *Salmonello* and many strains of *B. proteus*.

Q *But if I use* KANTREX *Injection, won't thot help make bacteria resistont to it olso?*

Next page, please .....

*Kanamycin sulfate injection (Bristol)

Q *But if I use* KANTREX *Injection, won't that help make bacteria resistant to it olso?*

A A very good question, hut it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

Q *My impression is thot* KANTREX *is just another neomycin. Isn't that so?*

A Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"[14]; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

Q *You mean that* KANTREX *Injection doesn't have the nephrotoxicity of neomycin?*

A Precisely. It's true that when KANTREX Injection is used, urinary casts — even slight albuminuria or microscopic hematuria — may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

Q *Then why do you recommend reduced dosoge in patients with renal impairment?*

A Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

Q *Is that why we see reports of patients developing heoring loss during* KANTREX *Injection therapy?*

A Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can be achieved with a fraction of the dose suggested for patients with normal kidney function — with minimal risk of ototoxicity.

Q *Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use* KANTREX *Injection in such conditions?*

A Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus*, *A. oerogenes* and *E. coli*, even when renal impairment is present.

Q *What are the "proper precautions" in a patient with impaired renal function?*

A The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more

QUESTIONS AND ANSWERS ABOUT KANTREX

is seldom required because the clinical response to KANTREX Injection is so rapid.

Q *Why do you put so much emphasis on* KANTREX'S *"rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

A There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.[1,2,3,7,8,9,11,15,16,19,21,22,26,29,32,33] Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[29]

Q *Does* KANTREX *Injection cause blood dyscrasias?*

A In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

Q *Can I administer* KANTREX *Injection in any other way than by the intramuscular route?*

A Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

Q *So you think I ought to use* KANTREX *Injection as my first choice antibiotic in staph and gram-negative infections?*

A Yes — because all evidence to date indicates that it is bactericidal against a wide range of organisms... rapid acting... does not encourage development of bacterial resistance... is well tolerated in specified dosage... and has not caused any blood dyscrasias.



KANTREX CAPSULES

for local gastrointestinal therapy... not for systemic infections

Q *Why can't I use* KANTREX *Capsules for systemic medication?*

A Because there is only negligible absorption of KANTREX from the gastrointestinal tract.[3,5,6,8,28,34] Thus, capsules cannot provide effective blood levels.

Q *Then what are* KANTREX *Capsules used for?*

A Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *I've been using neomycin for preoperative bowel sterilization. Why should I switch to* KANTREX *Capsules?*

A Because KANTREX has been rated as "superior to neomycin" for this purpose.[6] It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.[5,6]

Q *What advantages do* KANTREX *Capsules offer me in the treatment of intestinal infections?*

A A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella, Shigella, Staph. aureus, E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."[31]

KANTREX

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS
Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives": genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

DOSAGE: INTRAMUSCULAR ROUTE
Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

TOXICITY
When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION
KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

PRECAUTIONS
Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY
Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.
KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (for local gastrointestinal therapy; not for systemic medication)

INDICATIONS AND DOSAGE
For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION
Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY
KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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PUBLIC HEALTH PAGE

The Tuberculosis Problem In Kentucky

RUSSELL E. TEAGUE, M.D.

Commissioner of Health
Commonwealth of Kentucky

Prevalence

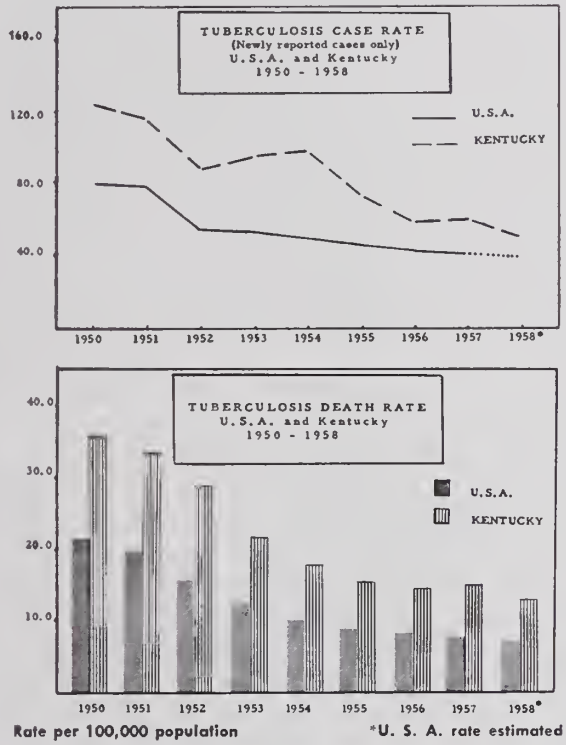
THE case rate of 51.5 per 100,000 for newly reported cases of tuberculosis represents 1,563 *new* active cases of tuberculosis in the State of Kentucky in the year 1958. Case register records indicate that 4,640, or 72.3% of the *total* known active cases, are not hospitalized and that a majority of these are not receiving adequate treatment. By county, the percentage not hospitalized or adequately treated varies from 42.6% in Lyon County to almost 100% in four other counties.

The Problem

There are several important reasons for failure to use hospital services. Financial difficulty is probably the most outstanding of these. Obviously, a patient whose hospitalization results in a complete loss of income or in a dangerously lowered standard of living for his family will be unwilling to remain idle in a hospital or will be unable to benefit fully from hospital care if he does accept it. This is a problem for the entire community rather than the individual alone. Inability on the part of the patient to accept hospital routine for long periods of time is another reason for not remaining under hospital care. Unawareness or even disbelief in the communicability of the disease on the part of the patient often leads him to scorn hospitalization or drug therapy. Physicians report that this same unawareness or disbelief on the part of the community as a whole permits known tuberculosis sufferers or suspects to remain at large in the community to spread the infection.

Further Investigation

The medical directors of the six state tuberculosis hospitals, located at Madisonville, Louisville, Paris, Ashland, London, and Glasgow, are currently making a follow-up survey of all patients who have ever been diagnosed as actively tuberculous, and are reporting on their present status and type of care. Incomplete reports from this survey indicate that, of 22 counties, 126 cases were recommended for hospitalization. Information for county-by-county planning should be available when this survey is complete.



Imperative Need for Action

Untreated active cases of tuberculosis represent a reservoir of infection which is largely responsible for Kentucky's comparatively high death rate of 13.0 per 100,000. Only one other state in the continental United States had a higher rate for the last reporting period. This rate can be improved only through *a coordinated program* of education and cooperative effort in each community.

internal and/or external attack

Whatever the bacterial infection seen in EENT, the foci respond rapidly to a suitable form of broad-spectrum ACHROMYCIN. In superficial cases, local therapy is often dramatic. In deep-seated conditions, ACHROMYCIN V capsules complement topical control for fast relief and remission.

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e Ophthalmic Oil Suspension 1%
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Ophthalmic Ointment 1%
with Hydrocortisone 1.5%
Ophthalmic Powder Sterilized

e Ear Solution

n Nasal Suspension
with Hydrocortisone
And Phenylephrine

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ACHROMYCIN V (Tetracycline with Citric Acid) Capsules

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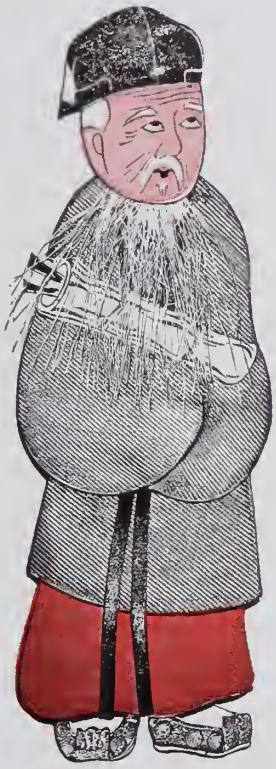
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Improvements Announced In Series E and H Bonds

Improvements in Series E and H Savings Bonds, effective June 1, 1959, are summarized in the following fact sheet issued by the Treasury Department —U. S. Savings Bond Division, 236 Federal Building, Louisville:

1. New Series E bonds with issue dates of June 1, 1959, and after earn 3¾% compounded semi-annually, if held to maturity (instead of former 3¼%). The increase from 3¼% to 3¾% is accomplished by reducing the term of the bond to 7 years, 9 months (instead of former 8 years, 11 months).

2. New Series H bonds with issue dates of June 1, 1959, and after earn 3¾% if held to maturity (instead of former 3¼%). The new H bond, like its predecessor, is a current-income bond, issued at par, redeemable at par (on one month's notice after six months' holding), and maturing at par at the end of its ten-year life.

There are also improved redemption values and investment yields if the new E bonds are held for less than the 7¾ years to maturity.

When held for:	Redemption value per $100 bond	Yield for: Period held	Yield for: Period remaining to maturity
1-½ years	$78.04	2.67%	4.01%
3 years	82.64	3.26	4.05
5 years	89.60	3.59	4.03

As before, interim yields on the new H bonds are approximately the same as the new E's for equal periods of holding. Interest checks after the first three will be level providing 4% current income after 1½ years of holding.

3. All outstanding E and H bonds purchased prior to June 1, 1959, earn at least 1½% more than before from now to next maturity. Present bonds earning 3¼% or 3% for their full current maturity periods will earn ½% more. Those earning 2.9% will earn 6/10% more. There will be lesser improvement in yields if redeemed earlier. The increase will be on a graduated scale, starting with next full interest period beginning June 1, 1959, or after. There is no retroactive increase in interest rates for periods prior to June 1, 1959.

4. Extension privileges on E bonds:
   a) Unmatured bonds:
      1. Issued June, 1949, through April, 1957, (which had not reached maturity before June 1, 1959) on which a 10-year 3% extension had already been promised, will now earn 3¾% for the entire extension period if held the full 10 years, with lesser yields (beginning at approximately 3½%) if redeemed earlier. (The redemption value of any bond at the beginning of the new extension will be the base upon which interest will accrue during the 10-year extension period).
      2. Issued beginning with May, 1957, will have a 10-year extension privilege, interest rates and other terms and conditions to be determined as they approach maturity.
   b) Matured bonds, issued May, 1941, through May, 1949, which are already in their extension period and which will begin to reach second maturity in May, 1961, have been given a second 10-year extension. (Other terms and conditions including interest rates to be determined as they approach extended maturity).

Monthly Payroll Savings Accumulation Table with New Series E Bonds

SAVE EACH MONTH	AND YOU WILL HAVE In 3 Years	In 5 Years	In 7 Years & 9 Months
$3.75	$139	$241	$396
6.25	233	403	661
7.50	280	484	794
12.50	466	807	1,323
18.75	701	1,214	1.991
25.00	934	1,617	2,652
37.50	1,402	2,428	3,981
75.00	2,805	4,856	7,963

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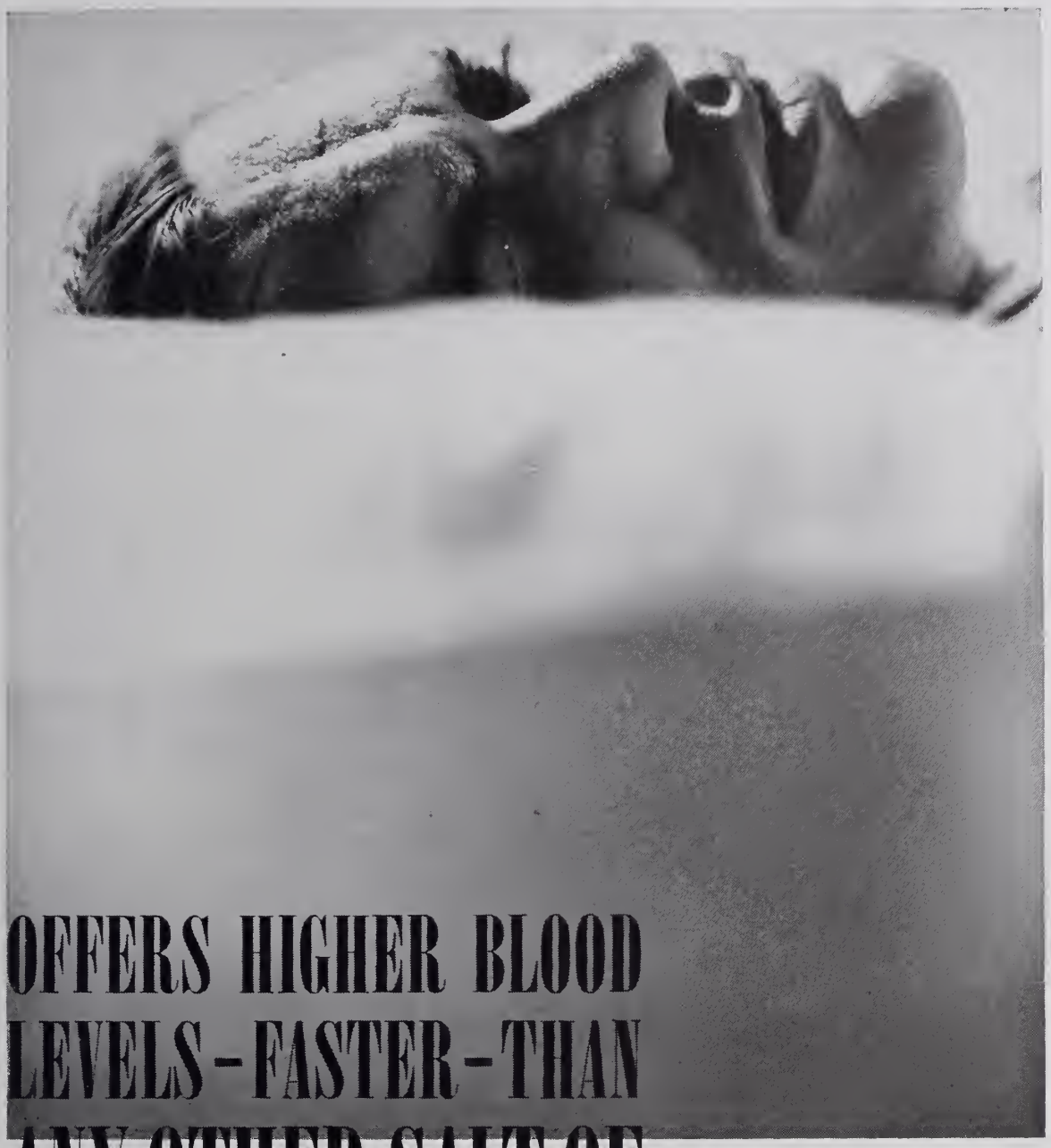
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Potassium Penicillin V

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Supplied: Compocillin-VK Filmtabs, 125 mg. (200,000 units), bottles of 50 and 100; 250 mg. (400,000 units), bottles of 25 and 100. Compocillin-VK Granules for Oral Solution come in 40-cc. and 80-cc. bottles. When reconstituted, each 5-cc. teaspoonful represents 125 mg. (200,000 units) of potassium penicillin V.

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in tiny, easy-to-swallow Filmtabs® in tasty, cherry-flavored Oral Solution



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Results with "... antacid therapy with DAA are essentially the same as ... with potent anticholinergic drugs."

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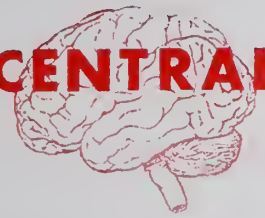
In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

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SYNEPHRICOL® cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

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Neo-Synephrine® hydrochloride	5.0 mg.
Thenfadil® hydrochloride	4.0 mg.
Dihydrocodeinone bitartrate	1.33 mg.
Potassium guaiacol sulfonate	70.0 mg.
Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

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The 10th annual meeting of the American Association of Medical Clinics was held September 24-26 at the Sheraton-Blackstone Hotel in Chicago.

Eligible for membership in the AAMC are clinics with seven or more full-time physicians. At least five of these physicians must be in different major specialties, two of which shall be internal medicine and general surgery. The group is required to maintain a separate building or group of offices for the conduct of its practice. AAMC publishes a monthly journal, "Group Practice."

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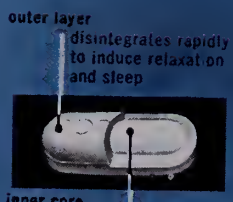
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For those patients who complain

carries your patients through the middle of the night





Each Nebralin timed-release tablet contains:

Dorsital* ..... 90 mg.
Warning: May be habit forming

Mephenesin ..... 425 mg.
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CAUTION: Federal law prohibits dispensing without prescription

Dosage: One or two tablets ½ hour before retiring.

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NEBRALIN is designed to duplicate the normal sleep pattern. It encourages muscular relaxation and induces sustained, relaxed sleep by the release of Dorsital and mephenesin in a timed-release tablet. Rapid-acting mephenesin quickly relaxes skeletal muscles to overcome "fatigue-tension" and conditions the body for sleep. Dorsital provides CNS sedation to induce sound, relaxed sleep. The initial and sustaining dosages are designed to keep the amount of barbiturate to be inactivated at any one time at a low level tapering toward morning. Evidence indicates that mephenesin is capable of producing sleep,[1] and when combined with a barbiturate enhances barbiturate action.[2,3] Moreover, the integrated action of the two components permits smaller dosages of each,[4] assuring your patients refreshed awakenings without "morning hangover."

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in pneumonia

. . . into a mixed culture of the three organisms commonly involved in pneumonia . . . *K. pneumoniae*, *Diplococcus pneumoniae*, and *Staphylococcus aureus* (in this case a resistant strain) . . . we introduce the five most frequently used antibiotics.

Twenty-four hours later (in this greatly enlarged photograph), note that only *one* of the five leading antibiotics has stopped *all* the organisms, including the resistant staph! This is Panalba.

In your next pneumonia patient . . . in *all* your patients with potentially-serious infections . . . provide this extra protection with your prescription:

Dosage—1 or 2 capsules 3 or 4 times a day.
Supplied—Capsules containing Panmycin phosphate equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin as novobiocin sodium, in bottles of 16 and 100.
Now available: new Panalba Half-Strength Capsules in bottles of 16 and 100.

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(Panmycin* Phosphate plus Albamycin*)

The broad-spectrum antibiotic of *first* resort



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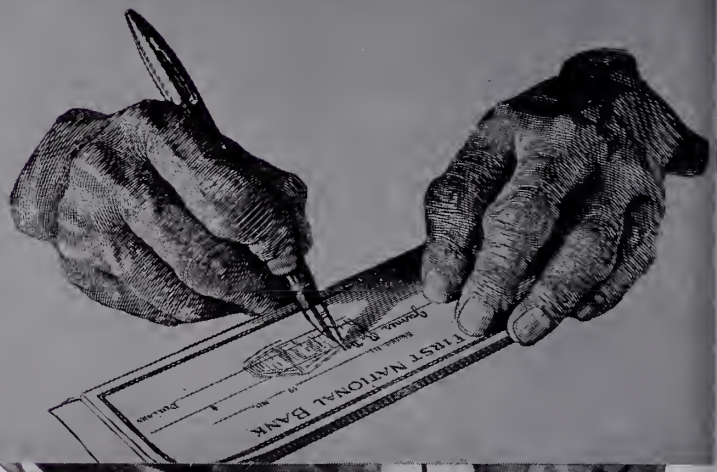
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WITHOUT STEROIDS

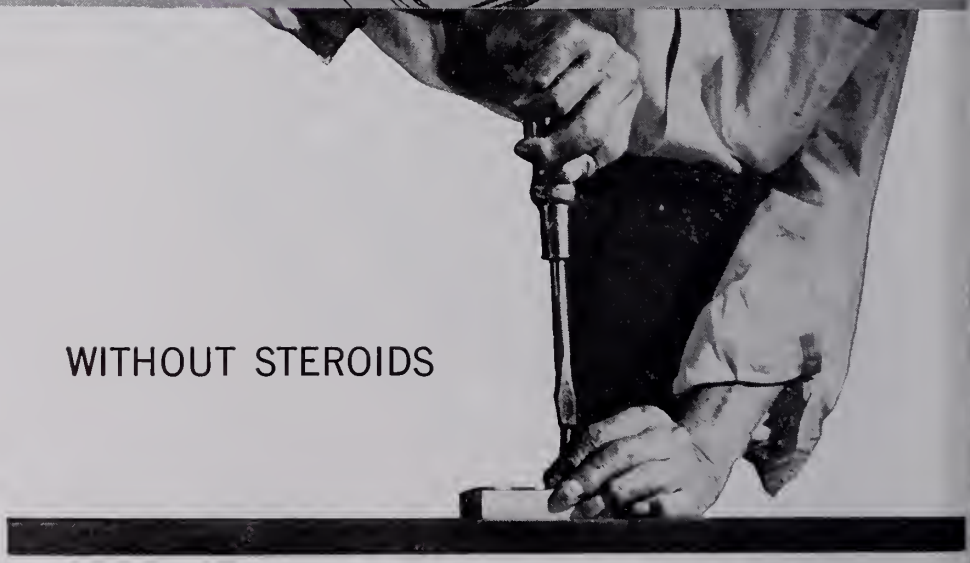


In every arthritic state..

WITHOUT STEROIDS



WITHOUT STEROIDS



MAINTENANCE THERAPY WITHOUT STEROIDS IS FUNDAMENTAL

Sound, conservative therapy with salicylates has been consistently reaffirmed as basic, long-term maintenance therapy in the arthritides.

Buffered Pabirin provides superior maintenance therapy. It epitomizes fundamental long-term basic therapy since it can be given month after month without serious complications and with minimal problems to patient and doctor alike.

Buffered Pabirin is formulated to provide high and sustained salicylate blood levels. Each tablet consists of an outer layer containing a buffer (aluminum hydroxide), para-aminobenzoic acid, and ascorbic acid; a core of acetylsalicylic acid.

In the stomach, the outer layer quickly releases the buffer, which protects against nausea, dyspepsia and other gastrointestinal symptoms so frequently encountered with salicylates alone. The core of Buffered Pabirin then disintegrates rapidly, permitting rapid absorption of the acetylsalicylic acid for faster pain relief.



Photographs show 2-stage Tandem Release disintegration.

Each tablet contains:
Acetylsalicylic acid (5 gr.).....300 mg.
Para-aminobenzoic acid (5 gr.)....300 mg.
Ascorbic acid ..... 50 mg.
Dried aluminum hydroxide gel....100 mg.

All Buffered Pabirin is sodium- and potassium-free.

Dosage: Two or three tablets 3 or 4 times daily.

References: 1. Hart, D.; Bagnall, A. W.; Bunim, J. J., and Polley, F. H.: Ninth International Congress on Rheumatic Diseases, Toronto, Ont. (June 25) 1957. 2. Report of Joint Committee, Medical Research Council & Nuffield Foundation, Treatment of Rheumatoid Arthritis, British Medical Journal (April 13) 1957. 3. Friend, D. G.: New England J. Med. 257:278 (Aug.) 1957.

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disorder
is more
than salicylates
alone
can control...

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MESSAGE FROM THE PRESIDENT

The Kentucky General Assembly

The Kentucky General Assembly will meet on the first Tuesday after the first Monday in January 1960. The Senate, consisting of 38 members, will be called to order by the Lieutenant Governor; and the House, consisting of 100 members, by the Chief Clerk of the previous session. Of these 138 members, 18 Senators were holdovers, 39 members were re-elected and 81 were newly elected on November 7, 1959.

In the Legislative Assembly of 1958, 1,021 Bills and 237 Resolutions were introduced. Amongst these were 74 measures with medical implications. A review of recent years discloses a gradual, steady growth in the number of Bills introduced each year with a corresponding increase in the number of those pertaining to medicine. This legislative burden will surely continue to expand.

Ninety-five Legislative Agents (Lobbyists) were registered in the 1958 Assembly. Their function was to both protect and further the interests of the groups they represented. This included an acquaintance with and a knowledge of each Legislator, a thorough familiarity of each Bill as it was introduced and subsequently published, and a daily perusal of the Legislative Record, the official summary of Legislative Action by the Kentucky General Assembly.

All of this is legitimate and necessary, for as a matter of practical politics the activities in connection with a Bill begin long before its introduction into the Legislature. Indeed, the future of many Bills is decided before it is reported out of committee for action on the floor. Once such a situation develops, it is difficult and sometimes impossible to alter the course. And should there be a contest on the floor, the continuing preparation and planning of weeks can not be negated by the frenzied efforts of the last moments.

Mr. Bobbie Grogan, the Director of Field Service, will reside in Frankfort during the 1960 General Assembly as the official Legislative Agent of the Kentucky State Medical Association.

You are urged to meet the Legislators in your community. All men depend upon the opinions, judgment, and knowledge of those whom they know and respect for guidance in matters with which they may not be familiar. Such acquaintanceships permit you to convey your views on legislative questions to interested people; and offer to them an opportunity, should they so wish, to consult with you concerning medical problems. On any other basis, once a question enters the legislative field of "Special and Selfish Interests," communications lose most if not all of their effectiveness.

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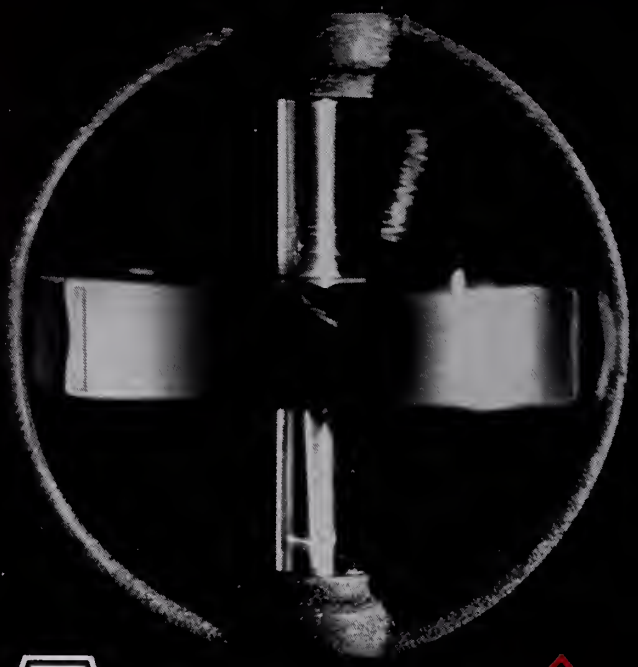
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References: 1. Feinberg, S.M., Feinberg, A.R., and Fisherman, E.W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J.I. and Sherwood, H.: *Connecticut Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S. and Friedlaender, A.S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M.S. and Duvenci, J.: *Bull. Tufts North East M. Center* 4:71 (April-June) 1958. 5. Segal, M.S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Sherwood, H. and Cooke, R.A.: *J. Allergy* 28:97 (Mar.) 1958. 7. Duke, C.J. and Oviedo, R.: *Antibiotic Med. & Clin. Ther.* 5:710 (Dec.) 1958. 8. McGavack, T.H.: *Clin. Med.* (June) 1958. 9. Freyberg, R.H.; Berntsen, C.A., and Hellman, L.: *Arthritis and Rheumatism* 1:215 (June) 1958. 10. Hartung, E.F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Hartung, E.F.: *J. Florida Acad. Gen. Pract.* 8:18, 1958. 12. Zuckner, J.; Ramsey, R.H.; Caciolo, C., and Gantner, G.E.: *Ann. Rheum. Dis.* 17:398 (Dec.) 1958. 13. Appel, B.; Tye, M.J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 14. Kalz, F.: *Canad. M.A.J.* 79:400 (Sept.) 1958. 15. Mullins, J.F., and Wilson, C.J.: *Texas State J. Med.* 54:648 (Sept.) 1958. 16. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: *J.A.M.A.* 167:959 (June 21) 1958. 17. DuBois, E.F.: *J.A.M.A.* 167:1590 (July 26) 1958. 18. McGavack, T.H.; Kao, K.T.; Leake, D.A.; Bauer, H.G., and Berger, H.E.: *Am. J. Med. Sc.* 236:720 (Dec.) 1958. 19. Council on Drugs: *J.A.M.A.* 169:257 (Jan. 17) 1959. 20. Rein, C.R.; Fleischmajer, R., and Rosenthal, A.R.: *J.A.M.A.* 165:1821 (Dec. 7) 1957.

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THE INSURANCE PAGE



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BLUE SHIELD of Kentucky was started in 1949 by doctors for the people—to help them prepay, or budget in advance, for unexpected surgical and in-hospital medical costs.

The Plan is administered by a Board of Trustees, composed of 75 per cent doctors and 25 per cent laymen who serve without pay. Blue Shield is non-profit in operation.

Doctors recognized such a plan was necessary because:

1. The average family budgets its income for practically all purchases and an amount must be allocated for good prepayment health protection.
2. The public must have available, on a voluntary basis, protection that would do the following:
   a. Be continued by people who develop chronic or incurable conditions.
   b. Provide protection for people who retire, or reach the age of 65 years or more.
   c. Allow dependents of deceased employees and retirees to continue protection.
   d. Permit children who become of age to retain their membership with no loss of accumulated protection.
   e. Allow transfer of membership from one company to another, or one state to another.

   (Such protection was not available. Any plan that fails to do these things is contributing to medical economic problems—not solving them.)
3. Control of the practice of medicine should remain in the hands of doctors, and only by establishing their own prepayment mechanism would this continue to be possible.

For additional information about Blue Shield write:

The Blue Shield Plan
3101 Bardstown Road
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The Insurance Page

It has been suggested by some of the readers of the Kentucky State Medical Journal that it would serve a useful purpose if some of the articles which appear on the Insurance Page from time to time could be reprinted for distribution by physicians.

The accompanying article has been prepared with the above suggestion in mind. The history and the basic philosophy of the Blue Shield idea in Kentucky are presented in a few brief paragraphs.

If an appreciable number of our Kentucky physicians indicate that they would like to have this, and future similar articles to give to their patients, reprints can be made available through the facilities of Kentucky Physicians Mutual, and may be obtained on request by writing to the Blue Shield Plan, 3101 Bardstown Road, Louisville 5, Kentucky.

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You can expect to see the same excellent response to NIAMID in a wide variety of depressive syndromes — acute or chronic, mild or severe, whether associated with long-standing or incurable illness, or masquerading as organic disease.

NIAMID side effects are infrequent and mild, and often lessened or eliminated by a reduction in dosage. NIAMID has not been reported to cause jaundice, and significant hypotensive effects have rarely been noted.

DOSAGE: Start with 75 mg. daily in single or divided doses, and adjust according to patient response. NIAMID acts slowly, without rapid jarring of physical or mental processes. Some patients respond to NIAMID within a few days, but for full therapeutic benefit, most require at least two weeks. NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

Complete references and a Professional Information Booklet giving detailed information on NIAMID *are available on request from the Medical Department, Pfizer Laboratories, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.*

NIAMID

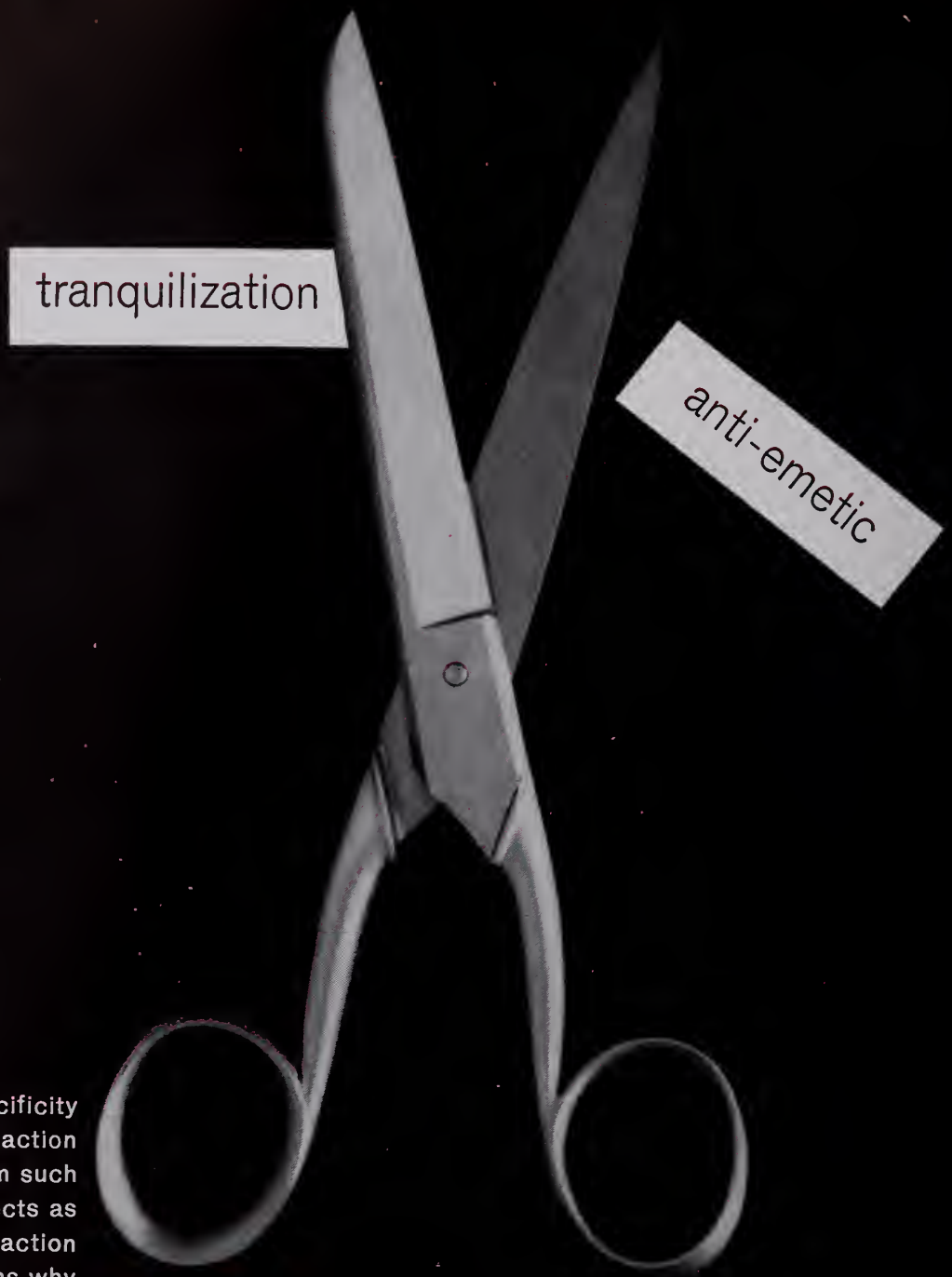
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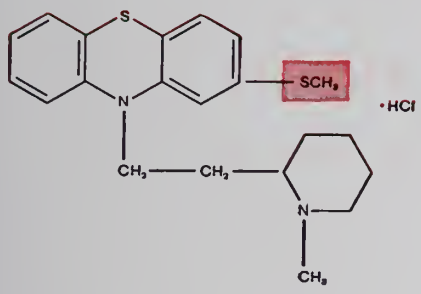
Mellaril®

THIORIDAZINE HCl

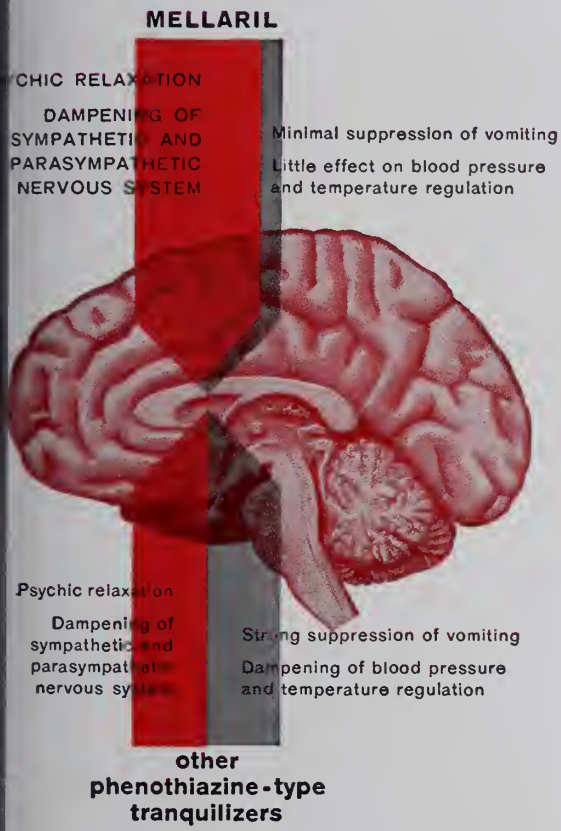
is virtually free of such toxic effects as · jaundice · Parkinsonism · blood dyscrasia

"Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines.... This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."*

new advance in tranquilization:
reater specificity of tranquilizing action results in fewer side effects



The presence of a thiomethyl radical (S-CH₃) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:



1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.



2 Less "spill-over" action to other brain areas — hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.

3 A notable absence of extrapyramidal stimulation.

4 Lack of impairment of patient's normal drive and energy.

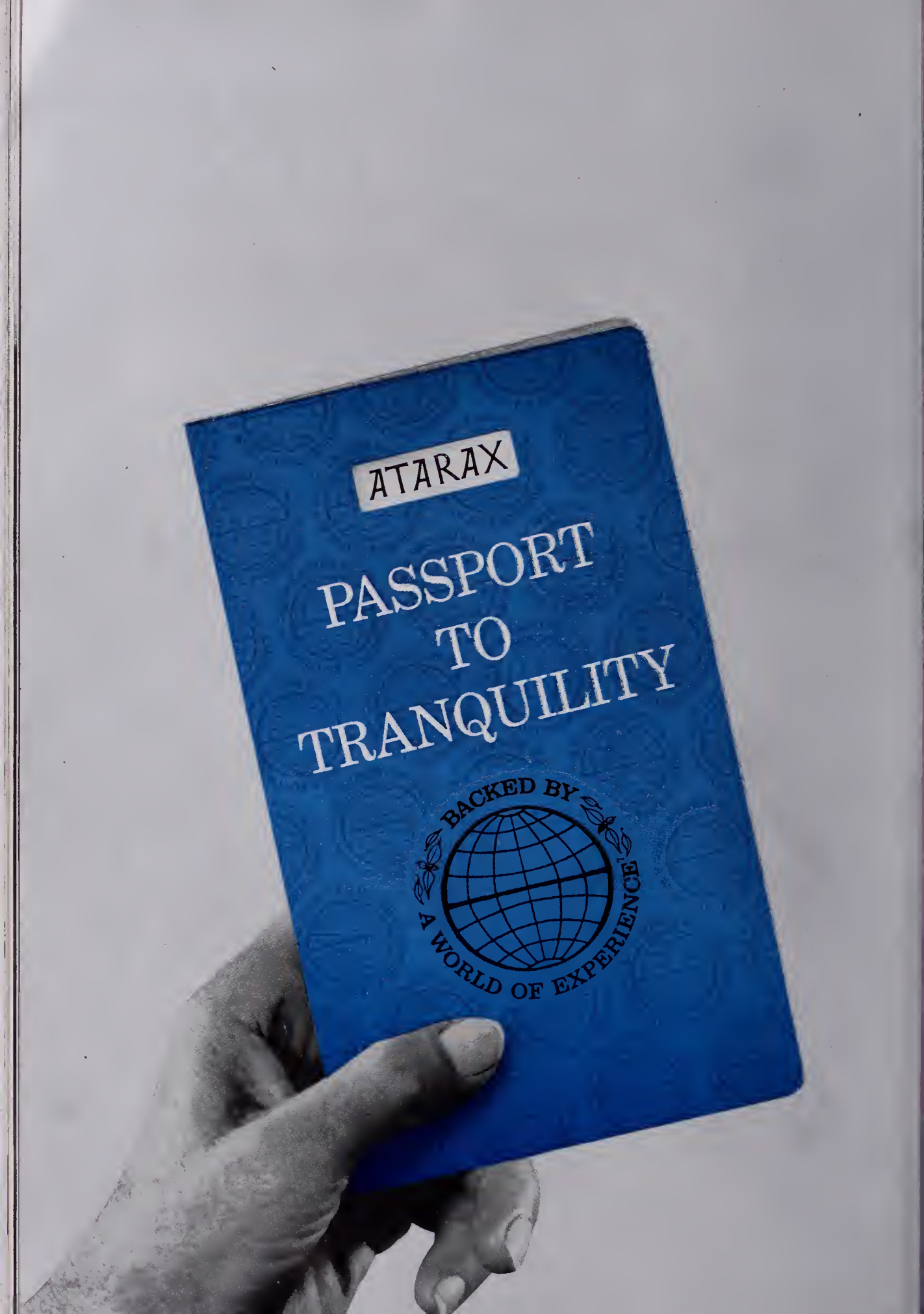
5 Virtual freedom from such toxic effects as jaundice, photosensitivity, skin eruptions, blood forming disorders.

INDICATION	USUAL STARTING DOSE	TOTAL DAILY DOSAGE RANGE
ADULTS: Mental and Emotional Disturbances:		
MILD—where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE—where agitation exists in psychoneuroses, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE—in agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN: BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

ELLARIL Tablets, 10 mg., 25 mg., 100 mg.

tfeld, A. M.: Scientific Exhibit, American Academy General Practice, San Francisco, April 6-9, 1959

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Dosage: ADULTS, one 25 mg. tablet, or one tbsp. Syrup q.i.d. CHILDREN – 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution, 10 cc. multiple-dose vials.

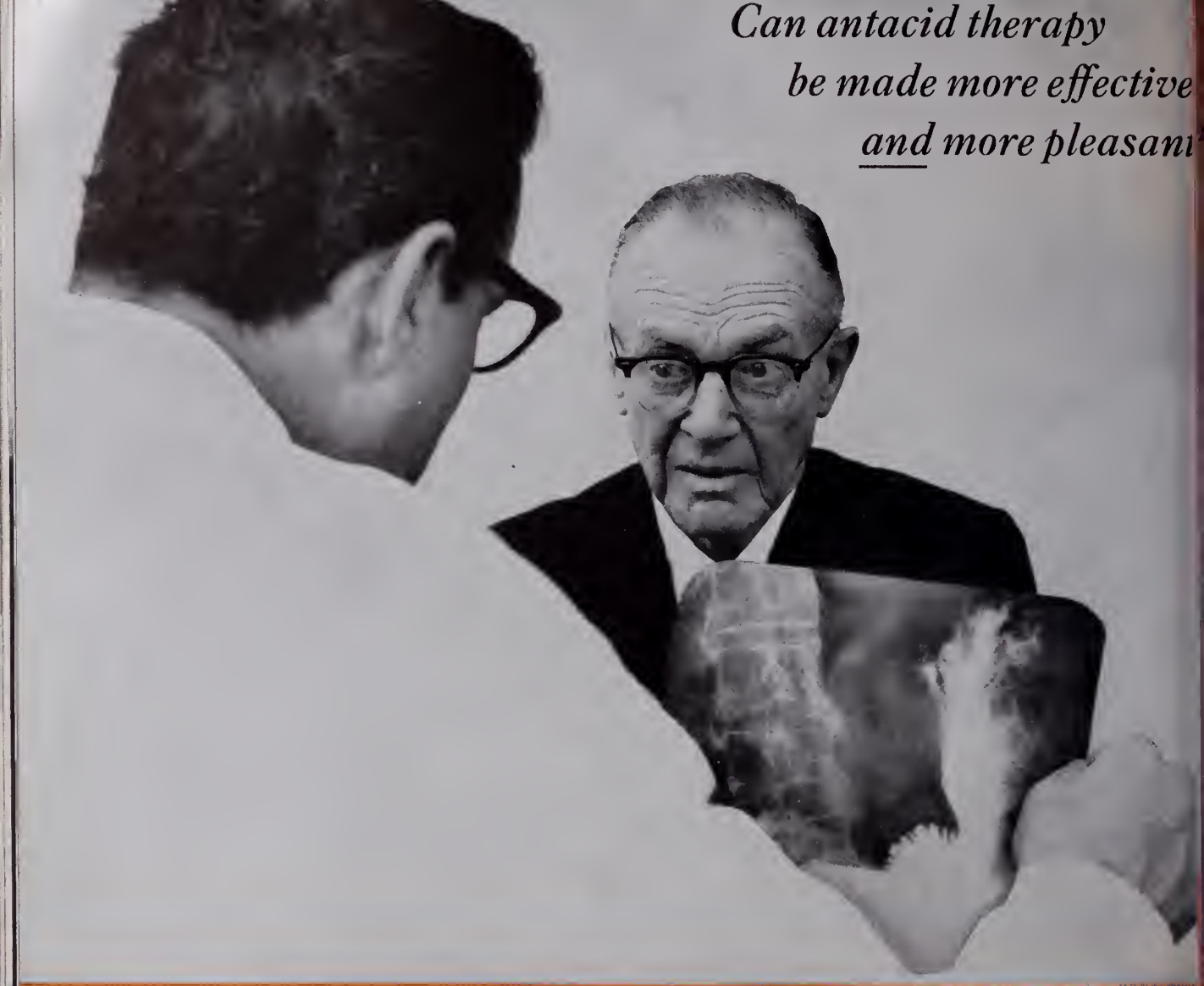
References: 1. Farah, L.: Internat. Rec. Med. *169*:379 (June) 1956. 2. Smigel, J. O., et al.: J. Am. Geriatrics Soc. *7*:61 (Jan.) 1959. 3. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 4. Eisenberg, B. C.: J.A.M.A. *169*:14 (Jan. 3) 1959. 5. Maryssael, L.: Bruxelles-méd. *38*:141 (Jan. 26) 1958. 6. Pfleger, R.: Med. Klin. *53*:1030 (June 5) 1958. 7. Over 200 laboratory and clinical papers from 14 countries.

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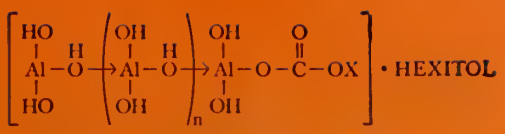
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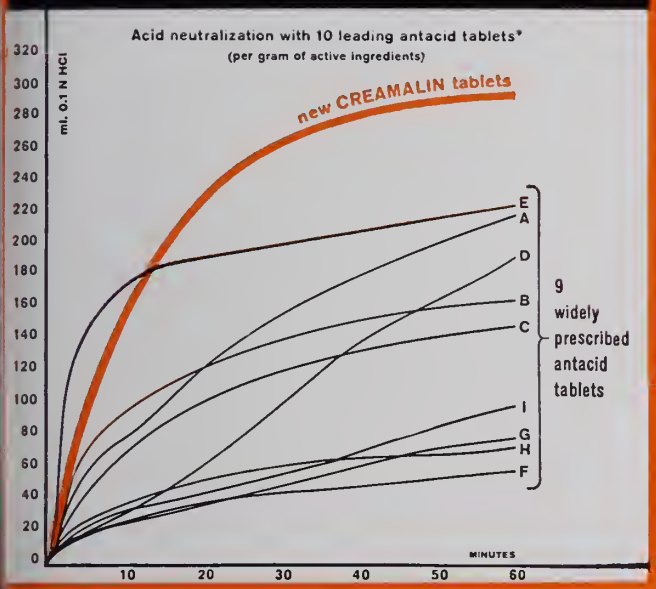
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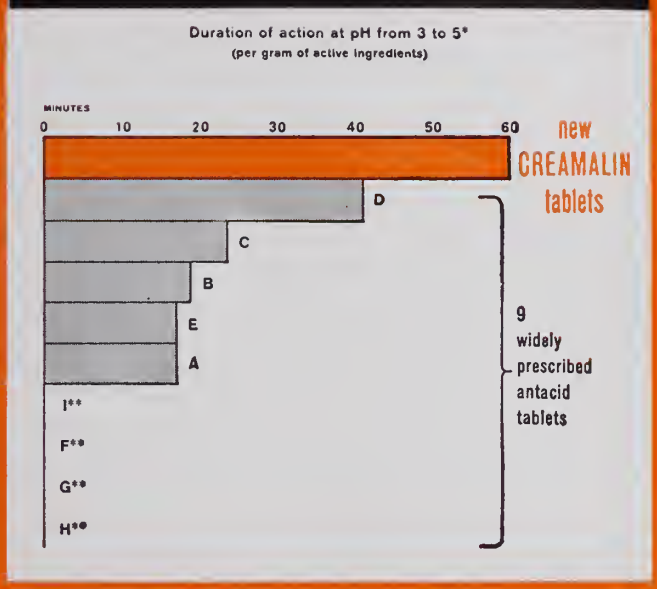
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Tablets were powdered and suspended in distilled water in a constant temperature container (37°C) equipped with mechanical stirrer and pH electrodes. Hydrochloric acid was added as needed to maintain pH at 3.5. Volume of acid required was recorded at frequent intervals for one hour.

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More Lasting Relief



*Hinkel, E. T., Jr., Fisher, M. P. and Tainter, M. L.: A new highly reactive aluminum hydroxide complex for gastric hyperacidity. To be published.
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No chalky taste. New CREAMALIN tablets are not chalky, gritty, rough or dry. They are highly palatable, soft, smooth, easy to chew, mint flavored.

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Adult Dosage: Gastric hyperacidity: 2 to 4 tablets as necessary. Peptic ulcer or gastritis: 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed with water or milk, or allowed to dissolve in the mouth.

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WASHINGTON NEWS DIGEST

Washington, D.C.—A special committee of consultants to the Federal Government has recommended what was termed an urgent, essential program designed to maintain the present ratio of physicians in a sharply expanding population.

Leroy E. Burney, M.D., Surgeon General of the Public Health Service, gave his personal approval to the recommendations made by his 22-member Consultant Group on Medical Education after about a year's study. But he said he couldn't indicate yet "the extent to which they can be incorporated" in next year's proposals of the Department of Health, Education and Welfare.

The Consultant Group recommended expansion of existing medical schools and construction of 20 to 24 new ones with Federal help, Federal scholarships for medical students, and greater efforts in the field by states, local communities, foundations, individuals, industry and voluntary agencies.

11,000 Graduates by 1975

The Group said the present ratio of 133 doctors of medicine and 8 doctors of osteopathy per 100,000 population is "a minimum essential to protection of the health of the people of the United States."

To maintain this ratio the Group said, "the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975—an increase of 3,600 graduated.

"To meet the country's need for physicians for medical care, teaching, research and other essential purposes will require an immediate and strenuous program of action by the nation as a whole," the Group's 95-page report stated.

Federal Funds No. 1 Need

"This program must safeguard and improve the quality of medical education as well as bring about the needed substantial increase in the number of physicians."

The No. 1 recommendation of the Group was for the Federal Government to appropriate over the next 10 years funds—estimated at about $500 million—"on a matching basis to meet construction needs for medical education," including necessary teaching hospitals.

"The Consultant Group is convinced that the nation's physician supply will continue to lag behind the needs created by increasing population unless the Federal Government makes an emergency financing contribution on a matching basis toward the construction of medical school facilities," the report said.

* * *

The Group also said research grants to medical schools "should cover full indirect costs so that medical schools are properly reimbursed for the contribution of medical education to medical research."

These two recommendations were in line with American Medical Association positions on the matters.

More Support Urged

The Group also urged "more generous public and private support for the basic operations of medical schools." Such support, the report added, "must come from many sources, including state and local appropriations, endowments, gifts and grants, universities, and reimbursement for patient care."

Most of the consultants were physicians or educators. They included Julian Price, M.D., of Florence, S. C., a member of the AMA Board of Trustees, and Edward L. Turner, M.D., Director of the AMA Division of Scientific Activities.

* * *

Highlights of the Group's report included:

To maintain the present physician-population ratio, the expected 1975 population of 235 million will require a total of 330,000 doctors of medicine and osteopathy.

There also must be 12,000 entering students in 1971, as against about 7,600 a year now.

"In a very real sense, the needs for physicians cannot be met by numbers alone. They will be met only as an expanded program maintains and enhances the quality of medical education."

The entry of more physicians into research, industrial medicine and similar activities "has made possible much of the progress of modern medicine." But it also has resulted in "relatively fewer physicians devoting full time to patient care."

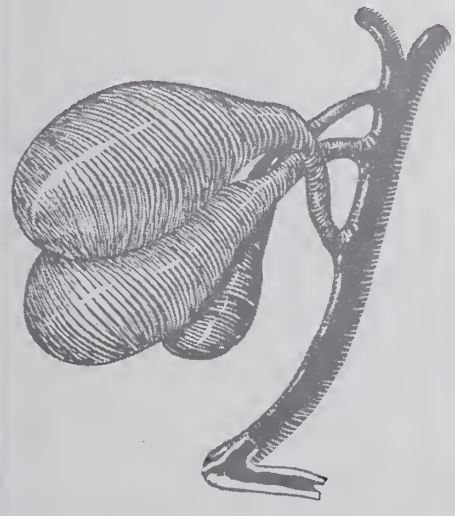
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Source: Skilboe, B.: Am. J. Clin. Path. *30*:252, 1958.



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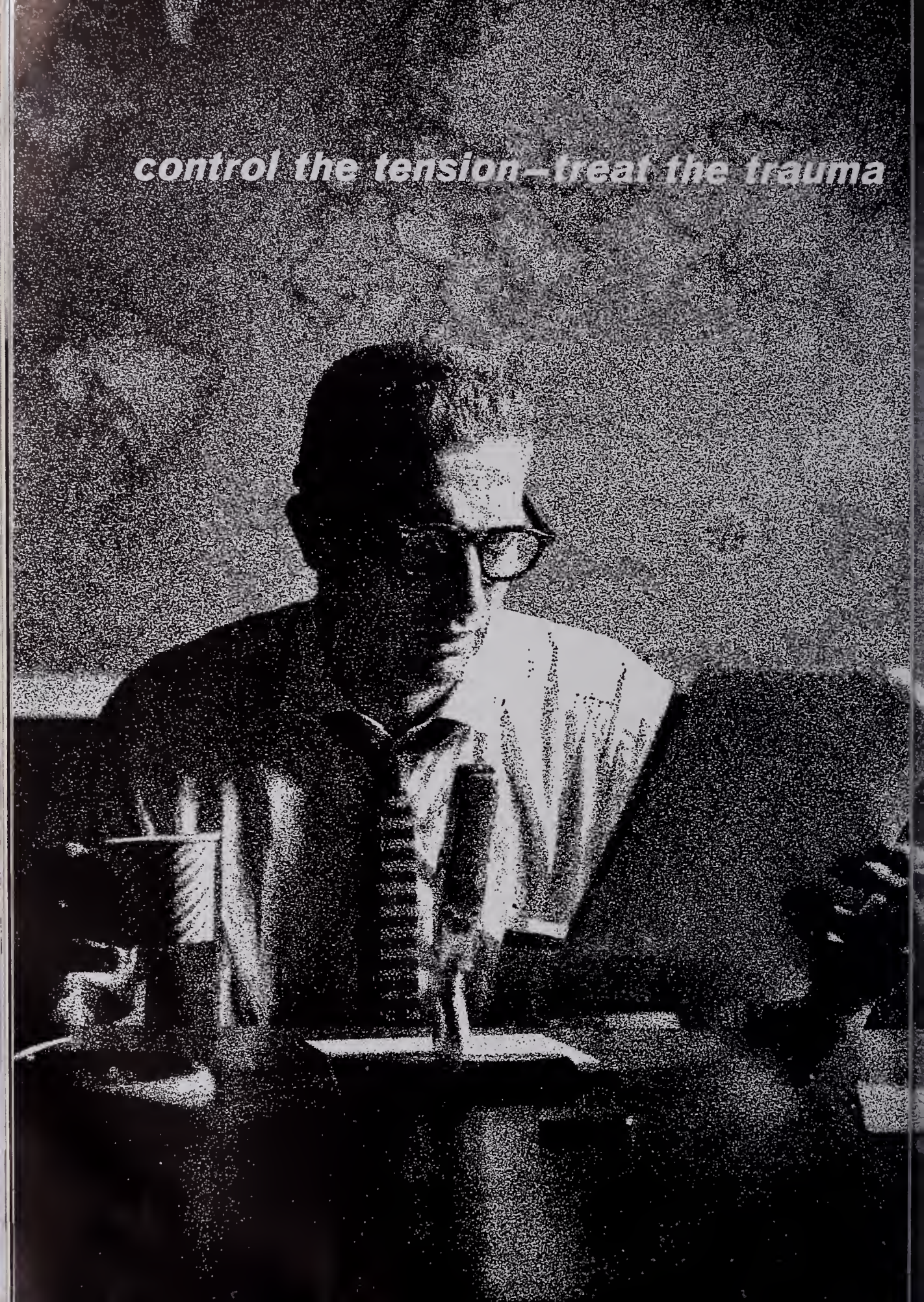
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"...DECHOLIN/Belladonna in a dosage of one tablet t.i.d. for a period of two to three months may prove helpful in relieving postoperative symptoms, aiding the digestion, and facilitating elimination."[2]

(1) Beckman, H.: Drugs: Their Nature, Action and Use, Philadelphia, W. B. Saunders Company, 1958, p. 425.
(2) Biliary Tract Diseases, M. Times *85*:1081, 1957.

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Administration and Dosage: PATHIBAMATE-400—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

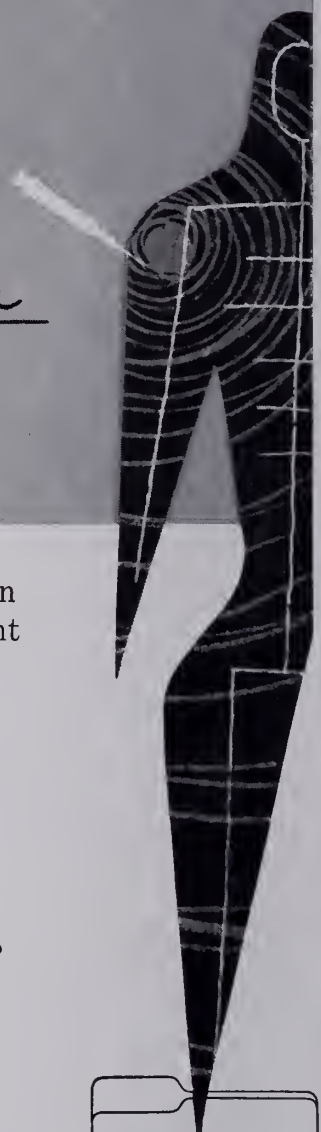
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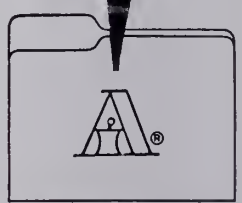
The Depinar special repository base permits slow absorption from the injection site, thus decreasing the need for frequent administration. Depinar continually bathes the tissues in vitamin B_{12} to provide more effective therapy and make patients feel better longer. A recent clinical report* shows over 98% of Depinar is retained after one week . . . and "Serum level vitamin B_{12} . . . sustained for 28 days or more from the single dose."

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*Thompson, R. E., and Hecht, R. A.: Am. J. Clin. Nutrition 7:311-317 (May-June) 1959.

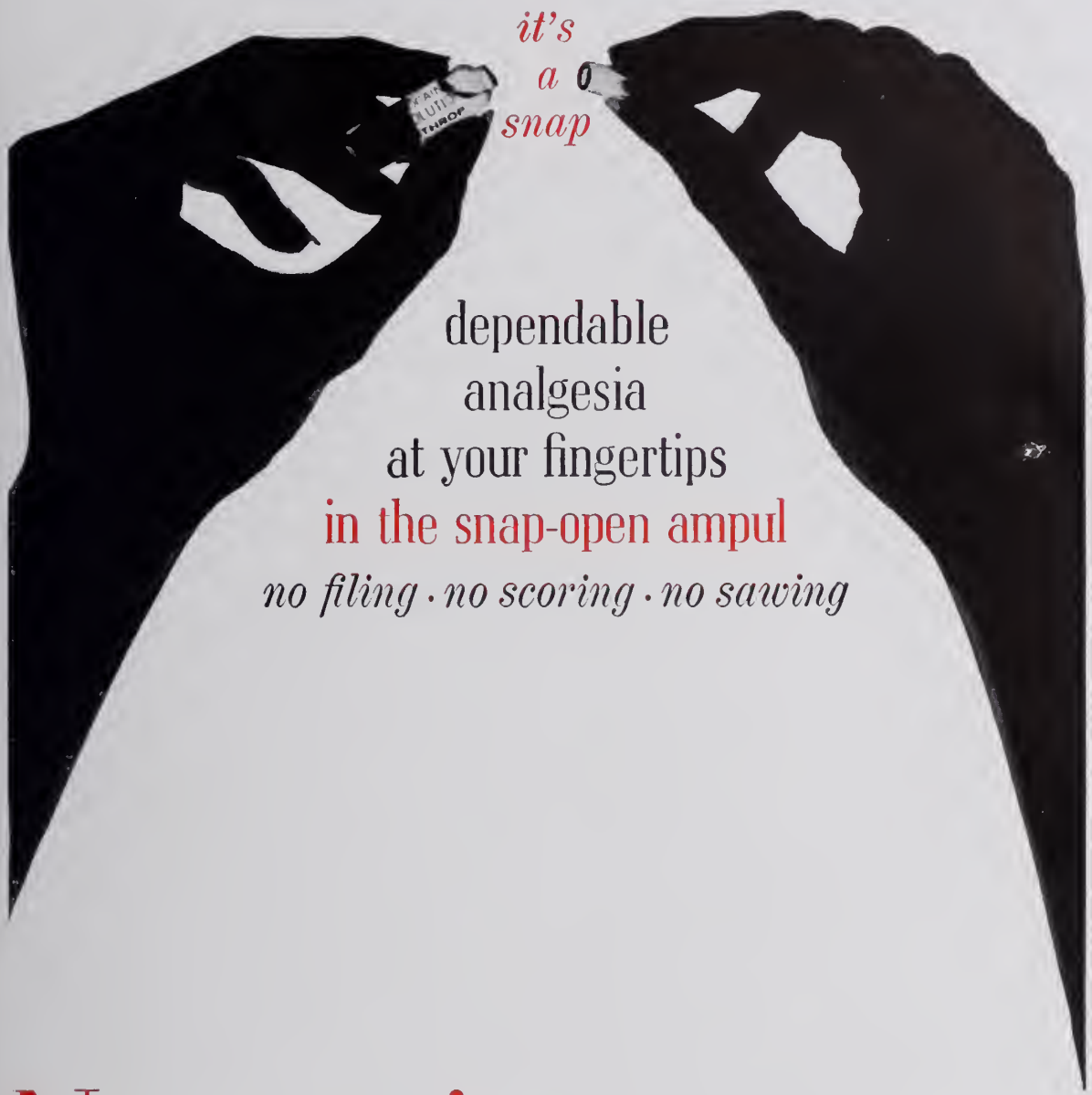
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Tetracycline-Triple Sulfa Combination (TETREX® c̄ T/S) in the Treatment of INFECTION

It is generally agreed that it is ideal to withhold antibiotic and chemotherapeutic drugs until after sensitivity tests show which antibacterial agent will be most effective. But very often, in actual practice, the physician knows that delay in starting antibacterial treatment may be detrimental to the welfare of his patient. He must then select the therapy to meet the most serious and immediate threats to the patient.

Why Combination Therapy?

Certain infections do not respond as well to a single agent as to a combination. *Hemophilus influenzae* infections, which are frequent in children, are a particularly serious threat to infants and children up to about 3 or 4 years of age since they have not yet built up any appreciable immunity. Serious complications such as influenzal pneumonia, empyema, or meningitis may develop, especially in this age group. In fact, except for those periods when meningococcal meningitis is epidemic, *H. influenzae* is the most frequent cause of meningitis.[1] This gram-negative organism is highly susceptible both to the tetracyclines and to the sulfonamides. Even in severe infections, therapeutic failure can be virtually eliminated by giving sulfonamides plus tetracycline.[1] These two agents together constitute the treatment of choice, and give better results than either alone.[2]

Sulfonamides remain the drugs of choice for all meningococcal infections, including meningitis. They readily penetrate the blood-brain barrier and pass into the cerebrospinal fluid in good concentrations.[3] In treating overwhelming meningococcal infections, and complicating infections of the upper respiratory tract caused by other organisms, the addition of tetracycline to sulfas can be valuable.[4]

In recent years the sulfonamides have again been prescribed more and more frequently. In certain serious infections, better results can be obtained with a combination of antibiotic and sulfonamide than with either drug alone (e.g., severe pneumococcal pneumonia or pneumococcal meningitis[5]). Furthermore, mixed infections, to which young children are particularly susceptible, often respond only to combination therapy such as tetracycline with sulfonamides (TETREX c̄ T/S).

Why Triple Sulfas?

Some sulfonamides, though therapeutically useful, frequently crystallize and cause renal damage. Sulfonamide mixtures are designed to prevent this effect. It is known that different substances can coexist in solution without interfering with each other's solubility. In such a solution each component behaves as if it alone were present. Thus, a much larger total amount of sulfonamide can exist in the urine without precipitating if a mixture is administered than if the same amount of only one compound is given.

Similarly, there is less danger of hypersensitivity with mixtures. The incidence of sensitization varies directly with the dosage and is limited to the particular sulfa given. Simultaneous use of several sulfa compounds, each in partial dosage, tends to keep each drug below its own sensitization level.[3] As with all sulfonamides, it is advisable to check for possible blood dyscrasias, rash, or renal toxicity during extended administration.

TETREX c̄ T/S, by combining only 167 mg. each of sulfadiazine, sulfamerazine, and sulfamethazine, practically eliminates serious renal damage and sensitization reactions due to sulfonamides while retaining the therapeutic efficacy of the total dose.

TETREX c̄ T/S can be administered with confidence in all severe and mixed infections due to tetracycline-sensitive and sulfonamide-sensitive organisms, including infections of the upper respiratory, urinary, and gastrointestinal tracts.

References: 1. Alexander, H. E.: The hemophilus group. In: Dubois, R. J.: Bacterial and Mycotic Infections of Man. Ed. 3, Philadelphia, J. B. Lippincott Co., 1958, p. 470ff. 2. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, pp. 1322-1323. 3. Beckman, H.: Drugs — Their Nature, Action, and Use. Philadelphia, W. B. Saunders Co., 1958, pp. 527-528. 4. Dingle, J. H.: Meningococcal infections. In: Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine. Ed. 9, Philadelphia, W. B. Saunders Co., 1955, p. 196ff. 5. Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics. Ed. 2, New York, The Macmillan Co., 1956, p. 1308.

TETREX® c̄ T/S

Antibiotic-triple sulfa combination in a palatable, cherry-flavored syrup.

Each 5 ml. teaspoonful contains:

Tetracycline (ammonium polyphosphate buffered equivalent to tetracycline HCl activity)	125 mg.
Sulfadiazine	167 mg.
Sulfamerazine	167 mg.
Sulfamethazine	167 mg.

This suspension may be stored at normal room temperature.

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... to unexcelled sulfa control of KYNEX. Lower dosage of just ½ Gm. daily ... prolonged action without hazard of crystalluria ... reduced toxic potential ... not surpassed by any other sulfa drug, singly or in combination. Dosage: Two tablets q.i.d. first day; one tablet q.i.d. thereafter. Each tablet contains: 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

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TRICHOTINE is the first major douche to contain sodium lauryl sulfate, a detergent of the highest order of efficiency. TRICHOTINE penetrates and dissolves the viscid film covering the vaginal mucosa; gets down in the rugal folds, carrying medication directly to the mucosa and the invading organisms.

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of many micro-organisms. "The douche solution is an effective agent against Trichomonas Vaginalis, Monilia Albicans, anaerobic organisms including a potent strain of streptococci that sometimes cause severe infections, and other non-specific vaginal micro-organisms."[1]

TRICHOTINE actually favors epithelial growth and healing, and the relief it affords from pruritis is quite striking.

For personal cleanliness, especially as a post-coital and post-menstrual douche, TRICHOTINE is designed to meet all the requirements of feminine hygiene. As an effective cleanser for office use, or for treatment, or for routine home douching, TRICHOTINE will prove satisfactory to you and its soothing, refreshing action will be reassuring to your patients. 1. Karnaky, K.J.: Med. Record and Annals, Houston 46:296 (Nov. 1952).

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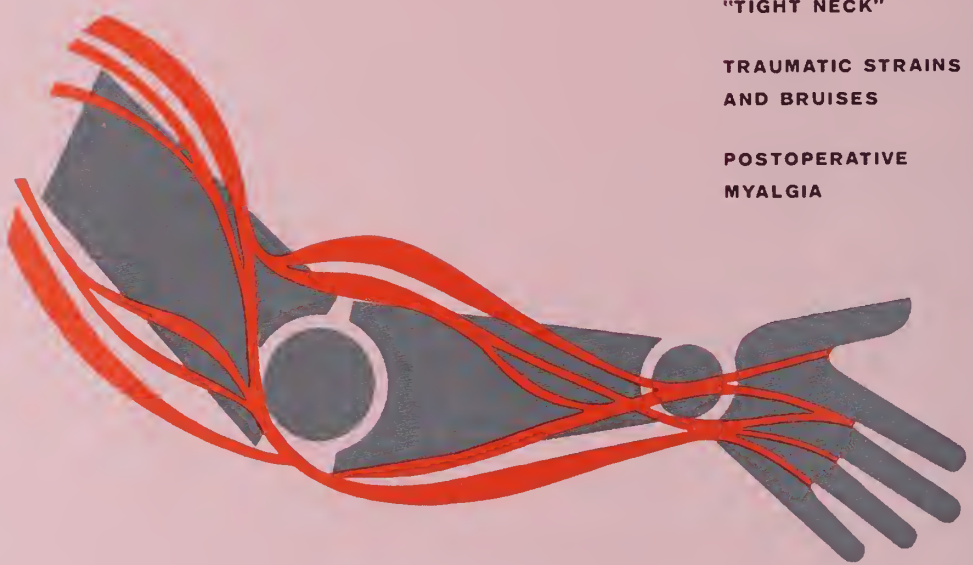
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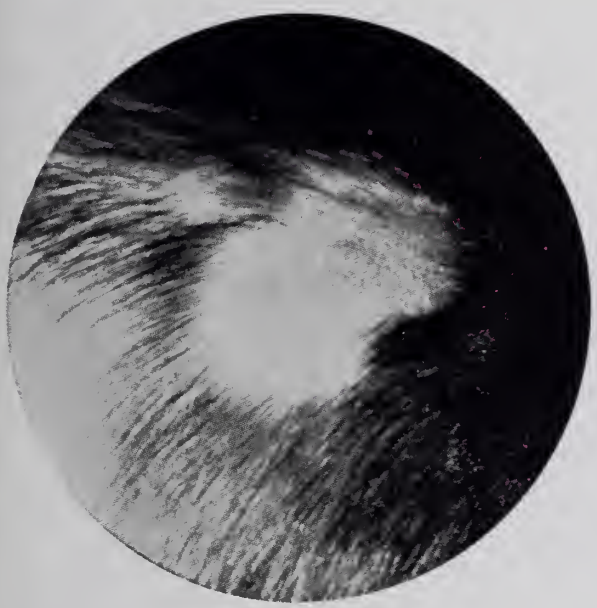
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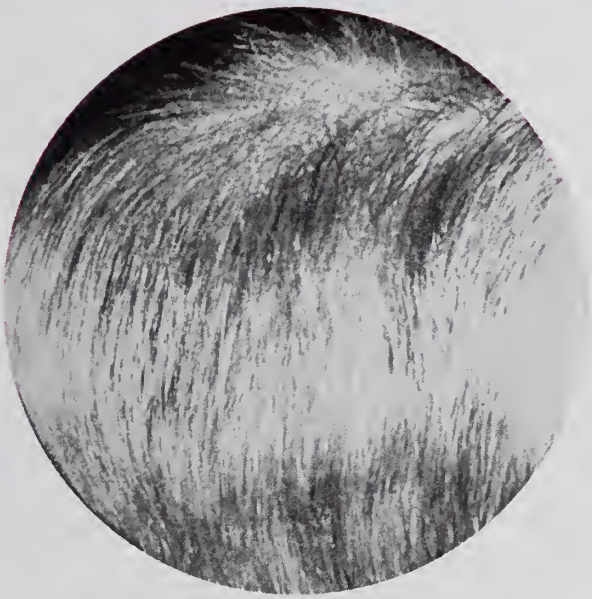
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1. Robinson, H. M., Jr., *et al.*: Griseofulvin, Clinical and Experimental Studies, A.M.A. Arch. Dermat., in press.

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Triacetyloleandomycin (TAO*)—Its Value In Acne And Certain Pyogenic Skin Eruptions

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Louisville, Ky.

THE part played by bacterial organisms in acne has not as yet been definitely established. The use of antibiotics systematically in the treatment of acne has undoubtedly been of value in certain selected cases, and in others the results have been disappointing.[1-6] This study was undertaken to ascertain the following:

1. Is TAO of value in controlling acne and other pyodermas?
2. What, if any, are the side effects of this drug?
3. Are bacterial sensitivity tests valuable, and can clinical results be predicted by such tests?

Historical

Oleandomycin was first described in 1955,[7] and in 1957 the discovery of an acetylated form, Triacetyloleandomycin, was announced.[8] In that same year, it was shown that the administration of a single 500 mg. dose of the acetylate preparation resulted in a blood level of 1.8 to 214 times that of the basic antibiotic when the same dose of the latter was given.[9] The newer preparation was reported to be effective in a number of bacterial infections. Clinical conditions in which the drug was useful included those from which such organisms as Beta hemolytic Streptococci, Staphylococcus Aureus and Albus, Neisseria Gonorrhea, and Klebsiella Pneumoniae were isolated.[10] Animal experiments and studies in vitro demonstrate that this antibiotic is effective in staphylococcus infections which are resistant to other antibiotics.

Method of Study

Ninety-seven (97) cases were selected at random for this study, but data was adequate in only seventy-two (72) cases, which is the basis for this report. All of the patients were ambulatory and were seen in private practice. Sensitivity tests were done by the disc method, employing the following antibiotics: Erythromycin, Nitrofurantoin (Furadantin), Chlortetracycline (Aureomycin), Dihydrostreptomycin, Novobiocin (Albamycin), Tetracycline phosphate, Oleandomycin (Matromycin**), Oxytetracycline (Terramycin), Kynex, Triple Sulfa, and Penicillin (Table I.). Usually the tests were performed prior to instituting therapy, but occasionally the drug was started the day the tests were performed. If the organism was

*The TAO used in this report was furnished by The Roerig Company, Division of Charles Pfizer & Company, Inc., New York.

**Unfortunately, although this is one of the oleandomycins, it is not chemically identical to TAO. No discs were available for the latter.

resistant and the patient was not improving, the drug was discontinued. In none of the cases was Triacetyloleandomycin the sole method of therapy. Local treatment, which in some cases included x-ray therapy, was employed. In many cases, therefore, it was difficult to judge accurately the true value of the antibiotic employed wherea;s, in other cases the improvement was so spectacular that it was felt that the drug was undoubtedly responsible for the improvement. This was particularly true in cases of folliculitis, furunculosis, and in cases of pyoderma complicating dyshidrosis of the hands. Patients were followed from two weeks to over twelve months, with the exception of a few in whom it was necessary to give the drug only five or six days in order to note the desired results.

Dosage

The patients were given a bottle of 60 capsules (250 mg. each) of Triacetyloleandomycin and advised to take four capsules daily, preferably after meals and at bedtime. The dosage was somewhat flexible, so in certain cases only three capsules were taken and in a few younger individuals two capsules were ingested. In those patients that took the medication longer than two weeks, the dose was gradually adjusted to a maintenance dose of one or two capsules daily. Not infrequently, the patients were a rather good judge of the dosage, for when a flare-up occurred they would increase the dosage until the condition was under control.

Bacterial Studies

The bacterial flora varied but was usually of the staphylococcic group, namely staphylococcus aureus and albus, some being coagulase positive and others coagulase negative. In some infections, however, streptococci were recovered, and when such organisms as Proteus sq. and Aerobacter aerogenes were reported we questioned their significance. We were unable to show any correlation between the coagulase reaction and the improvement of the patient. The results of the sensitivity studies are shown in Table I. Although in most cases one could predict the clinical response by correlating sensitivity tests with the drug of choice, there were notable exceptions. There were several patients who continued to improve even though bacteriological studies showed resistance to that particular antibiotic. In one case, the patient relapsed and was then placed on a different antibiotic to which the organism was sensitive and made an uneventful recovery without further relapse. Another patient who had an extensive massive pyoderma involving the neck showed remarkable improvement after prolonged and unsuccessful previous treatment with other antibiotics to which the organisms were also sensitive. The patient subsequently relapsed, however, under Triacetyloleandomycin, but is now again showing marked improvement under this drug. As a rule, however, if the tests revealed sensitivity in low concentration then some improvement usually followed prolonged use of the drug in adequate dosage. When the dosage was diminished or the drug discontinued, the patients usually relapsed but again improved with reinstitution of the drug. Occasionally, however, some patients would flare-up even when the drug was being administered in what seemed to be sufficient dosage. We have no satisfactory explanation for this unless the organism had become resistant to the particular antibiotic employed, or there was an overgrowth of non-susceptible organisms. Repeated sensitivity studies might have been very valuable in such cases.

TABLE I
Results of Sensitivity Studies on Sixty-Seven (67) Cases of Acne and Pyodermas

Drug—positive to:	Number of cases
*Nitrofurantoin (Furadantin)	34 (89%)
Erythromycin	57 (85%)
*Dihydrostreptomycin	28 (73%)
Chlortetracycline	48 (71%)
Novobiocin	46 (68%)
Oleandomycin (Matromycin)	45 (67%)
Tetracycline Phosphate	44 (65%)
Oxytetracycline (Terramycin)	42 (62%)
Kynex	32 (48%)
Triple Sulfa	24 (35%)
Penicillin	22 (32%)

*Based on thirty-eight (38) cases only.

A total of seventy-two (72) cases were studied and complete sensitivity studies were done on sixty-seven (67) (Table I.). Several other antibiotics were employed in testing other than those shown in the table, but too few tests were performed to permit a critical analysis so that they were omitted from this report. It is

felt that this drug would probably have revealed a higher percentage of sensitivity reactions had we been able to employ the acetyloleandomycin discs in the actual performance of these tests. In spite of this, however, its therapeutic efficiency in most cases and its freedom from reactions in the cases studied make it a drug well worthwhile employing in the treatment of the pyodermas. One of the most interesting aspects of this study is the resistance of so many of the organisms to penicillin (68%). Undoubtedly, as the population increases its contacts with newer antibiotics, more organisms will become resistant, and thus the pharmaceutical companies must continue their research in order to give us newer, safer, and more potent antibiotics if we are to win the race against the microbes.

Clinical Results

Often it was very difficult to appraise adequately the clinical results, as stated previously. In some cases, it appeared as though the drug was of definite value in controlling the condition, even though the sensitivity studies revealed that the particular organisms were resistant to the antibiotic employed. As a rule, however, if the tests revealed sensitivity in low concentration improvement usually followed prolonged use of the drug in adequate dosages.

Acne

A total of forty-one (41) cases were followed adequately. The duration of observation varied from four weeks to shortly over a year. In our opinion, this drug proved extremely valuable in the management of most cases and was exceptionally useful in the cystic and conglobata types. The value of antibiotics in the management of acne has been lauded by many investigators. It was not unusual to have patients inform us that they could control the intensity and frequency of exacerbations with the administration of the drug. When the drug was discontinued or the drug markedly diminished, there was definite efflorescence of new lesions. It is not to be implied, however, that any antibiotic is the last word in the treatment of acne. It should be administered, however, in all resistant cases and routinely in the cystic and conglobata types. The proper choice of antibiotics in the treatment of such cases has undoubtedly lessened our dependency upon x-ray therapy. We see no objection to keeping patients on small doses of antibiotics for many months, providing there are no gastrointestinal disturbances and blood counts at regular intervals reveal no abnormalities.

Pyodermas Other Than Acne

Although some of the milder pyodermas (impetigo) do not necessarily require systemic therapy, undoubtedly their duration is diminished and chances of the condition becoming epidemic or spreading throughout a family are greatly lessened when such therapy is administered. In our experience, Triacetyloleandomycin proved most effective in such cases, eliciting cures in every patient. Undoubtedly, other antibiotics would have proven equally as efficacious. We were particularly impressed with the response of furunculosis to this drug. After several days, the furuncles either rapidly suppurated or began to involute without necrosis. New lesions were few, and when the patients were kept on small maintenance doses (250 to 500 mg. daily), the attacks were either abated or markedly diminished.

TABLE II

	Number of Cases	Improved	Unimproved	Indeterminate
Acne	41	29	5	7
Furunculosis	11	8	1	2
*Secondary Infected "Eczematous" Conditions	6	6	0	0
Impetigo	5	5	0	0
Sycosis Barbae	2	2	0	0
Folliculitis	2	2	0	0
Infected Sebaceous Cyst	2	2	0	0
Leg Ulcers	2			
a. Pyodermic	1	1	0	0
b. Thrombophlebitic	1	0	0	1
Extensive Pyodermas of Neck	1	1	0	0
TOTAL	72			

*These included secondarily infected "Eczema", Dyshidrosis, and Neurodermatitis.

In the handling of secondarily infected eczemas, the use of Triacetyloleandomycin proved invaluable.

Grouping all of the clinical cases together, we felt that treatment was effective (marked improvement while on the drug or cured) in fifty-six (56) cases (78%); ineffective (unimproved) in six (6) cases (8%); and we were unable to judge accurately the results in ten

(10) cases (14%). There were no side reactions discernible. One patient developed a maculopapular eruption while under treatment and Triacetyloleandomycin was discontinued temporarily. The drug was then reinstituted and no further reaction developed, so it is very unlikely that this was a true dermatitis medicamentosa from Triacetyloleandomycin.

Conclusions

1. Seventy-two (72) cases of acne and other pyogenic skin eruptions were treated with Tao* (Triacetyloleandomycin). The results were satisfactory in seventy-eight percent (78%) of the cases.

2. Triacetyloleandomycin was of definite value in the management of most cases of acne.

3. In the few cases of other pyogenic infections in which Triacetyloleandomycin was used, cures were elicited in all.

4. The drug was safe in the recommended dosage and no complications were noted.

5. Although antibiotic sensitivity studies were of definite value in determining the drug of choice, some individuals responded favorably to Triacetyloleandomycin therapy even though the organisms were resistant in vitro.

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The Marfan Syndrome: A Study Of 5 Generations In a Kentucky Family*

ABRAHAM M. GORDON, M.D.**

Louisville, Ky.

THIS report will attempt to define a rare disorder of connective tissue best known by its eponym, the Marfan Syndrome, as it was found in five generations of a Kentucky family.

Definition

By definition the syndrome under discussion is a heritable disease of connective tissue manifested in the eye, skeleton and cardiovascular system. Known also as arachnodactyly, a term coined by Achard[5] to describe the spider-like appearance of the fingers and toes, this name is now rarely employed. Since connective tissue is widely distributed, consisting of many diverse materials, combined into many different structures, each with distinctive properties and functions, a disordered connective tissue may produce symptoms of unlimited proportions with multi-system involvement. The degree and scope of the connective tissue changes in the Marfan Syndrome, particularly as they affect elastic tissue, determines the severity of the disease and in turn generates the symptoms peculiar to this disorder.

Skeletal abnormalities were recognized and reported by Marfan[1] in 1896. Ocular and cardiovascular derangements went unappreciated and were slowly added by other observers in later decades. Boerger[2] described ectopia lentis and included disorders of the eye as an integral part of the syndrome. Etter and Glover[3] were the first to associate dissecting aneurysm with the disease. Baer, Taussig and Oppenheimer[4] ascribed aortic aneurysm in young adults to the Marfan Syndrome.

Recognized skeletal abnormalities will include tallness, a dolichocephalic skull, a highly arched palate, lax joints, kyphosis, pigeon breast or pectus excavatum, poor muscle tone, scant subcutaneous fat, pes planus, arachnodactyly, a mobile patella, hammer toes, misshapen ears and hernia. Ocular involvement affects the lens and the suspensory ligament. Ectopia lentis, microphakia, iridodonesis and defects within the zonular fibers may be present. Described cardiovascular disorders include valvular heart disease, aortic aneurysm, medial cystic disease of the aorta, dissecting aneurysm and congestive heart failure.

The family of the propositus has been studied and the pedigree appears on next page. Direct descent from a male ancestor five generations back lists 18 individuals in the pedigree of whom six are believed to have been affected.*** All six appear in the last three generations, including the propositus, his father, an uncle, one cousin, a brother, and one niece. Of the six, examination was possible in three of these cases. All three were tall, suffered with subluxation of the optic lens, lax joints, dolichocephalic skulls and deformities of the chest and spine. Two of the three cases examined have succumbed to cardiovascular complications. Autopsy in one case was permitted and the findings are included in this report.

Case Report 1.

(Hospital #32436)

On Sept. 23, 1946, a 24-year-old unmarried white male, a baker by trade, was hospitalized

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* *Presented to the Jewish Hospital Staff on November 24, 1957, as part of the hospital program in postgraduate medical education. Minor changes have been made for publication.*

** *Instructor in Medicine, University of Louisville School of Medicine.*

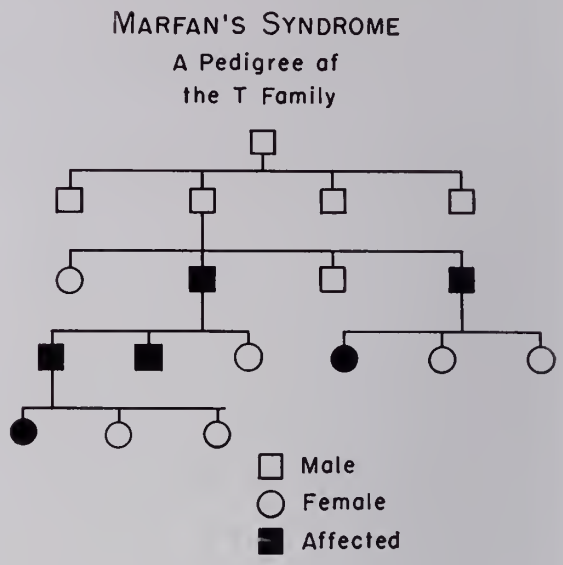
*** *Available information does not implicate others in the pedigree with certainty. The appearance of two cases in the third generation makes a mutation unlikely. The disease probably existed as a form fruste in the first and second generation or else the defect was introduced by a spouse.*

complaining of shortness of breath and weakness. Six months before admission he noticed increasing weakness and fatigability. He gave up his job in the bakery as he was no longer able to perform his assigned duties. In July, 1946, he developed pain in the left chest which he attributed to pleurisy. Beginning in August he developed constant nausea and stated that he vomited most of what he consumed. Seven days before admission he was seen by a physician because of severe pain in the left kidney region. The patient suffered the usual disorders of childhood. He denied rheumatic fever. At 16 years of age he was told he had "skipped beats" resulting from heart disease and should take things easy. In 1930 surgery on the right eye for subluxation of the optic lens was successfully accomplished, with removal of the lens. On the same day an older brother had the identical operation in the right eye, also for ectopia lentis. The patient's father died at 44 years of age of heart disease, having suffered a lifetime with his eyes.

Physical Examination

Physical examination revealed a poorly nourished, thin white male who measured over 6 feet in height. Respiratory distress was moderate and he appeared chronically ill. His temperature measured 98.6° F, pulse 116 and the respirations 26 per minute. The blood pressure measured 120/90 mm. of Hg. The head was dolichocephalic. The right cornea (operated eye) was opaque, the eye soft, shrunken and totally blind. The left pupil reacted sluggishly to light. Upward and inward subluxation of the optic lens was seen with the ophthalmoscope. The iris appeared tremulous. The hard palate was narrow and highly arched. The neck veins were visibly pulsatile and distended. The thyroid was normal. The chest appeared moderately pigeon breasted. Rales were heard in both lung bases and persisted after cough.

The heart was enlarged to the left as the PMI was palpable in the 6th ICS at the anterior axillary line. A systolic thrust was felt to the left of the sternum. A thrill was palpable at the apex. A systolic murmur was audible over the whole precordium, loudest at the apex and along the left sternal border. At times a faint diastolic murmur was reported in the aortic area. The liver edge descended two fingers be-



The Pedigree

I-a. Birth 1815. Death at an age and cause unknown. Married twice. All offspring are believed to result from first mating.

II-a. Birth 1841. Death at 70. Liver disease?

II-b. Birth 1844. Death at 77, cause unknown. Wife died at age 75.

II-c. Birth 1847. Death at 50, cause unknown.

II-d. Birth 1850. Death at 60 with "locked bowels."

III-a. Birth 1880. Living. History does not suggest Marfan's Disease. Not available for examination.

III-b. Birth 1884. Death at 44 years of age with "dropsy." Tall and thin. Eye trouble all his life. Sired propositus. Wife born in 1893 and died of meningitis in 1927.

III-c. Birth 1887. Living. Eye trouble all his life. Short in stature. Probable form fruste?

III-d. Birth 1890. Death at 54 years of age with heart disease. Eye trouble all his life. Tall and thin. Sired three daughters one of whom died of heart disease at 32.

IV-a. Birth 1917. Death at 37 with dissecting aneurysm. Ectopia lentis,. six foot, four inches in height, severe pectus excavatum (case #2.). Sired three daughters one of whom is affected.

IV-b. Birth 1923. Death at 24 years from intractable heart failure. The propositus of this report. The image of his father according to surviving sister. Typical Marfan's Syndrome. Necropsied.

IV-c. Birth 1920. Living. Free of eye disease. Normal stature.

IV-d. Birth date unknown. Suffered with eye trouble all her life. Died at 32 years with heart disease.

IV-e. Birth date unknown. Believed to be normal.

IV-f. Birth date unknown. Believed to be normal.

V—a. Birth 1945. Living. Dislocated optic lens in one eye. Tall, thin, scoliosis of spine, dolichocephalic. Typical Marfan's Syndrome.

V—b. Birth 1947. Living. Examined. Not affected.

V—c. Birth 1948. Living. Examined. Not affected.

(The source of the pedigree was III-c, IV-a, IV-b, IV-c, the wife of IV-a, other relatives not shown in the pedigree, as well as the family Bible.)

low the costal margin on deep inspiration. Splenic enlargement by palpation was not found. All reflexes were hypoactive. Pitting edema of moderate degree was present in both ankles and up the leg as high as the knee. Moderate clubbing of all fingers and toes was seen. Rectal examination was negative. The genitalia were clinically normal.

Laboratory Studies: His hemoglobin measured 15 grams. The red blood count was 5.2 million per cu. mm. The white blood count totalled 6,700 with 67% polys., 31% lymphs., 2% eosin. A hematocrit of 52 was reported. The urine was amber, acid, sp. gr. 1.014, with a trace of albumen, one plus sugar and negative acetone. Microscopic examination of the urine revealed 1 to 2 casts per high power field and a rare rbc. The NPN measured 74 mg%. The plasma proteins totalled 5.81 grams. An icterus index of 16 was reported.

Course In The Hospital: With digitalis whole leaf in full doses, a low salt diet, bed rest and diuretics, a fair degree of compensation was obtained. Pulmonary congestion diminished. The heart rate slowed to 96 per minute. The NPN fell to 63.1 mg.%. An electrocardiogram was interpreted as showing a right ventricular strain pattern. A six foot chest film revealed a moderately enlarged heart, pulmonary congestion and elevation of the right hemidiaphragm. On 11-2-46 the patient was dismissed with instructions to continue the hospital regime at home. One week later he was readmitted as his condition at home had deteriorated. A gallop was now audible. Venous pressure measured 180 mm. of water. The blood pressure now measured 150/90. Four weeks later he was discharged without any visible improvement. On 2-24-47 he entered the hospital for the last time. Anasarca, orthopnea and abdominal distention were now severe. Opiates were required for relief. All measures were to no avail and the patient expired on 3-7-47.

Report of Necropsy

Necropsy was performed three hours after death. "The body is that of a young male with severe generalized edema. The right cornea is opaque. The conjunctivae are mildly icteric. The chest is symmetrical, with little subcutaneous fat. The abdomen is distended with fluid."

"Serous Cavities: Each pleural cavity contains about 400 c.c. of dark amber fluid. Adhesions at the apex were freed. The peritoneal cavity contained 2,000 c.c. of light amber fluid. The pericardial cavity is free of fluid or adhesions.

"Aorta and Vessels: The aorta follows a normal anatomical course but appears hypoplastic in the ascending portion of the arch, where it measures 6.2 cm. (normal 7.4 cm.). There is nothing else remarkable about the great vessels.

"Lungs: The right lung weighed 400 grams, the left 430 grams. Both lungs lie collapsed in the pleural cavity. The lower lobes appear purple and subcrepitant. Infarcts are seen in both lower lobes.

"Heart: The heart weighs 480 grams (normal 300 grams) and shows marked dilatation of both ventricles. The epicardium is devoid of fat. The subepicardial vessels are brown and soft. The left ventricle measures 13 mm. (8-10) in thickness and the right ventricle 5 mm. (2-3). The tricuspid valve measures 140 mm. (120) in circumference, the mitral 105 mm. (100), pulmonic 80 (85), aortic 80 (85). All valves except the mitral are membranous and competent. The superior half of the mitral valve is densely adherent to the endocardial surface of the left ventricle anteriorly and at the upper margin of the valve there are small bony spicules protruding into the ventricular cavity. The margin of the valve shows only moderate thickening. There is no thickening of the chordae tendinae. There are no gross mural thrombi. There is no evidence of congenital heart disease, other than the hypoplasia previously described.

"Liver: The liver weighed 1600 grams. It extends several fingers below the costal margin. The capsule is smooth. The liver surface is a deep purple. Cut surface is nutmeg in appearance. The gall bladder and biliary tree are free of calculi.

"Pancreas, Adrenal and Spleen: Not grossly abnormal.

"Gastro-Intestinal Tract: Stomach moderately dilated. Marked thickening and edema of

the wall of the small bowel. The appendix is grossly normal.

"Genito-Urinary Tract: The right kidney weighed 210 grams, the left 220 grams. Both kidneys are swollen but show normal relationship of cortex and medulla. The bladder contained 300 c.c. of urine. The prostate appeared normal.

Microscopic

"Aorta: Section through the ascending aorta shows moderate increase in thickness of the intima. Some deposition of lipoid within mononuclear phagocytes and some hyalinization is seen. There is no distinct elevation of the intima. Media and adventitia are not remarkable.

"Heart: The vessels in the epicardial fat including the smallest capillaries are markedly congested. One coronary vessel shows a dark blue staining material forming a wavy ring about the inner margin of the intima. This appears to be some peculiar change in the inner elastic membrane. The superficial myocardial cells are moderately swollen and degenerated, their nuclei stain poorly. The mitral valve is hyalinized and acellular. At its base there are scattered mononuclear macrophages and an occasional polymorphonuclear leucocyte which has escaped through a small congested capillary. There is no real inflammatory reaction. Nor are there any Aschoff bodies in the myocardium. The endocardium is edematous but intact. The muscle cells of the papillary muscle tend to fragment and occasionally there is a brown pigment about the nuclei of some of these cells. Some thickening of the septa is seen in focal areas. Small microscopic mural thrombi were seen in some of the sections. About the calcified area in the mitral valve there is marked hyaline fibrosis which extends to the free margin of the valve. There is no inflammatory reaction to indicate recent activity.

"Spleen: The Malpighian bodies are small and compressed. The central arterioles appear normal. All sinusoids are congested.

"Liver: The central half of each lobule consists of a mass of hemorrhage which has completely destroyed the liver. The sinusoids are dilated. The Kupfer cells are so hypertrophic that they compress the hepatic parenchymal cells.

"Adrenals: Congested.

"Lungs: Heart failure cells are seen. Areas of infarction in both lungs are present. The septa are thickened and edematous.

"Kidney: The glomeruli are congested. An occasional fibrinous deposit in the periglomerular space is seen. The tubules show cloudy swelling, with occasional free rbc's in the lumen. The renal artery at the hilus shows some areas of calcification in the media. One small branch of the renal artery shows the same blue wavy line at the junction of the intima and media as was described in a coronary artery.

"Prostate and Seminal Vesicles: An area of chronic inflammatory reaction is present in the prostate.

"Stomach and Mesentery: Congestion of the vessels.

"Final Anatomic Diagnosis: Marfan's Syndrome, chronic mitral endocarditis with calcification, hypoplasia of the ascending aorta, cardiac hypertrophy and dilatation, bilateral hydrothorax, ascites, chronic passive congestion of liver, pulmonary infarction, pleural adhesions, phthisis bulbi, right."

Case 2.

The patient, a 30-year-old married white male, brother to Case 1, was examined at my request in April, 1947. He had no complaints and failed to understand the reason for the interview. He measured 6 ft. 4 in. and weighed 144 lbs. The head was dolichocephalic; the palate highly arched. A prosthesis was worn in place of the right eye. He related that following eye surgery for subluxation of the optic lens in 1930 he developed glaucoma. This was treated until 1944 at which time enucleation of the eye became necessary. Ectopia lentis in the left eye with upward and inward displacement was readily seen with the ophthalmoscope. Correctible vision with glasses, however, was 20/30 in the left eye. A severe degree of pectus

excavatum was present. The lungs were clear. The heart was not enlarged to percussion. Rhythm was regular. An apical rate of 80 per minute and blood pressure of 120/78 was recorded. The PMI was not displaced. A loud systolic murmur was audible over the entire precordium. All joints were lax. A mild degree of kyphoscoliosis was present. No other findings of note were found.

This patient unfortunately failed to return. Inquiry years later revealed that he had died suddenly. His physician gave the following account of his last illness. On April 4, 1954, he sought medical consultation complaining of mild chest pain, aggravated by swallowing. On April 9, 1954 he developed sudden severe chest pain and died moments later. At death, extravasated blood was seen in the subcutaneous tissue of the neck and face. Death was attributed to dissecting aneurysm with rupture. Autopsy was not permitted.

Examination of the three daughters sired by this patient revealed the Marfan Syndrome in the eldest. The usual skeletal deformities were well defined and the presence of ectopia lentis in one eye was confirmed by an ophthalmologist. At 12 years of age she measured 5 ft. 6 in. and weighed 86 lbs. She was doing well in her school work and her activity was not restricted. Evidence of cardiovascular involvement could not be found at the time of examination.



This patient was not a member of the T family discussed in the text. He was free of ectopia lentis although slit lamp examination revealed abnormal looseness and branching within the zonular fibres. A sister measured 5 ft. 11 in. with typical skeletal findings. Examination of the father and the family history confirmed the diagnosis.

Discussion

This communication adds a new family pedigree of the Marfan Syndrome to those previously reported. Diagnosis in our cases was established by the presence of ectopia lentis, the obvious skeletal defects and their proven genetic origin. Among members of the T family death at an early age from cardiovascular involvement was frequently recorded. English in descent, the family have lived in northern Kentucky for over 100 years. This origin was considered noteworthy when a paper by Williams[14] published in the 1870's was read. Williams practiced in Cincinnati, Ohio, a city less than 50 miles from the T family homestead. In his report he describes 2 cases of ectopia lentis in patients undoubtedly suffering with the Marfan Syndrome. It is of interest that his report appeared some 20 years before Marfan's publication. My attempt, however, to link his 2 cases with the T family was considered unsuccessful as the available facts failed to support such an agreeable hypothesis.

The practical importance of the disorder has been enhanced by the rapid progress made in cardiac and cardiovascular surgery within the last decade. Poor results[16] have followed attempts to repair vascular lesions in Marfan's Syndrome by surgical means. Surgical correction of eye defects have yielded equally poor results.[12] In our two cases blindness resulted in the eye of one patient and glaucoma followed in our second patient which eventually required enucleation, both as a consequence of surgical intervention. It would appear therefore that all elective surgical procedures in this group of patients had best be avoided. One need only recall the basic connective tissue defect inherent in these cases to realize why poor results with surgery can be predicted.

Published reports of necropsied cases have been reviewed[6,7,10,11,16] by others. Of autopsied cases 60% suffer aneurysm of the aorta while 30% succumb to dissecting aneurysm. Gore[17] attributes dissecting aneurysm to changes within the elastic lamella of the aortic media. Medial cystic disease is believed to parallel these

changes. Deposits of metachromatic coagulum and disorganization of smooth muscle when added to the lamellar changes within the media produce a thickening but weakening of the arterial wall.[7] The spread and confluence of these microscopic lesions may lead to one or more of the following: aortic aneurysm, aortic insufficiency, aneurysm of the sinuses of Valsalva, elevation of the coronary ostia, dissecting aneurysm, coronary insufficiency and congestive heart failure. Similar pathological changes[4,7] have been described in the pulmonary artery.

Uyeyama[8] and his coworkers were the first to report hypoplasia of the ascending aorta in the Marfan Syndrome. Succumbing to dissecting aneurysm found in the distal thoracic aorta, the ascending portion in their case appeared to escape this serious complication. Whitfield, Arnott and Stafford[9] have described hypoplasia of the ascending aorta in a second case of the Marfan Syndrome. In their report they also describe focal connective tissue changes within the myocardium which they interpreted as a myocarditis. These two cases were the only ones found in the literature to associate aortic hypoplasia with the Marfan Syndrome.

Our case is the third reported case to exhibit at autopsy hypoplasia of the ascending aorta and the second to report focal connective tissue changes within the myocardium. Whitfield's[9] case, unlike our patient, did not suffer with mitral valve disease. It is of interest, however, that both patients followed an inexorable downhill course succumbing to congestive heart failure and obtaining no significant relief with digitalis and other measures usually so successfully employed.

The belief has been expressed that heart failure can occur as a consequence of narrowing or hypoplasia of the ascending aorta. Moss[18] states a reduction of 50% or more in the intraluminal diameter of the aorta is required to significantly alter circulatory dynamics. A 50% reduction in the surface area of the aortic valve has been postulated in aortic stenosis before perceptible changes in hemodynamics becomes apparent. The modest reduction in intraluminal diameter suffered by our patient did not, it is believed, affect or alter this patient's clinical course.

Heart failure, it would appear in these cases, is unexplained and of obscure origin. The role of connective tissue residing within the myocardium in producing heart failure is undefined. Yet in acute severe rheumatic fever a disease recognized by its inflammatory effect on connective tissue elements within the heart as well as elsewhere, congestive heart failure is often fatal, especially in the young suffering their first attack. Poor results with digitalis in controlling heart failure is usual in these cases. Histologically, the muscle cells within the myocardium exhibit few changes and fail to correlate with the severity of the clinical picture. Aschoff bodies are frequently prominent in these cases yet as with the Marfan Syndrome modern histological techniques[16] have not been able to demonstrate the nature of the connective tissue derangement.

It would seem that the effects of the Marfan Syndrome on somatic growth may also result in an aorta that is longer, narrower and more vulnerable than normal. The disease produces at a later time, as a result of abiotrophy, the anatomical changes usually described at necropsy. The ascending aorta is known to contain a high content of elastic tissue and for this reason a site of predilection for the T. pallida in syphilitic aortitis. As the Marfan Syndrome also affects that part of the aorta richest in elastic tissue, the ascending aorta becomes the choice site of this disorder. This theory however fails to account for the cases reported by Uyeyama,[8] Whitfield,[9] and our own case.

Recently a patient with the Marfan Syndrome seen on the wards of this hospital was sent to the Growth and Development Center, of the University of Louisville, School of Medicine, for anthropometric study. All measurements, including that of the skull, fell into the normal range. Additional studies of this kind would be of great interest as these patients represent a unique and distinctive group within the human family.

Summary

A pedigree of the Marfan Syndrome in a native Kentucky family has been described. Six of eighteen members were found affected. Three of the six cases were examined and the diagnosis confirmed. Necropsy in one case exhibited hypoplasia of the ascending aorta, focal

connective tissue changes within the myocardium and calcific mitral valve disease. The rarity of these findings is discussed. The genetic origin of this disease is emphasized.

Acknowledgements

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CASE DISCUSSIONS
From The
University of Louisville Hospitals



Louisville General Hospital

Injuries Of Major Arteries

(A Case Report)

J. Alex Haller, Jr., M.D.*

MOST injuries to major arteries require immediate operation. This naked statement is eloquently supported by the results of brilliant front line vascular surgery in the Korean War.[1] The present case discussion demonstrates both the problems of initial vascular injury and the cruel consequences of secondary complications with delayed operative intervention in wounds of major peripheral arteries.

Case Report

This 37-year-old healthy colored male was stabbed with a butcher knife between the left coracoid process and the clavicle during a beer altercation on Saturday night, August 22, 1959. The skin wound was sutured at his local hospital where very little blood loss was noted. The radial pulse was present and no gross neurological deficit was detected, but fine objective testing was impossible because of his alcoholic stupor. The next morning the left shoulder was swollen and tender and the hand and forearm were becoming edematous with loss of finger function. Later that afternoon (August 23, 1959) the patient had a sudden coughing bout and an unknown amount of blood gushed from the previously sutured wound. He remained in constant pain from the swollen, almost immobile, left arm. A softball-sized pulsatile mass was first noted in the left infraclavicular area when the dressings were changed five days after the injury. Breath sounds were barely audible over the lower two-thirds of the left chest. He was transferred to the Louisville General Hospital two days after the pulsatile mass was first detected.

Admission Examination

Physical examination on August 29, 1959, revealed a muscular young colored male with pale conjunctivae, absent breath sounds to the left nipple line in an upright position and a tensely swollen left upper extremity, approximately twice the size of the right arm. A very weak radial pulse was present but no movement of the fingers could be elicited. Sensation was intact. Filling the left pectoral area was a tender warm pulsatile mass without thrills but with a loud systolic bruit. There was no diastolic murmur. The patient refused to move the left arm because of the excruciating shoulder girdle pain. An erythematous two-inch wound with sutures in place was noted over the left coracoid process. The blood pressure was 155/100 in the right arm; none was audible on the left. The pulse was 80, respirations 28 and temperature 98.8° F.

Admission laboratory examinations revealed: Hgb. 7.4 gms., Hct. 21, WBC 13,400 and urine negative.

Chest x-ray showed fluid to the left 2nd anterior rib but no pneumothorax.

Hospital Course

The patient was considered to have a large pulsating hematoma or false aneurysm of the left subclavian axillary artery with secondary hemorrhage into the left pleural space. Eleven hundred cc. of old blood were aspirated from

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the left chest without reaccumulation. He was placed on Chloromycetin 2 gm/day and Streptomycin 1 gm/day and given 4 units of blood over the next two days. On the morning of the third day an operative retrograde arteriogram was carried out through the left superficial femoral artery. Films were taken at 6/ sec. with the Elema-Schonander machine. The study

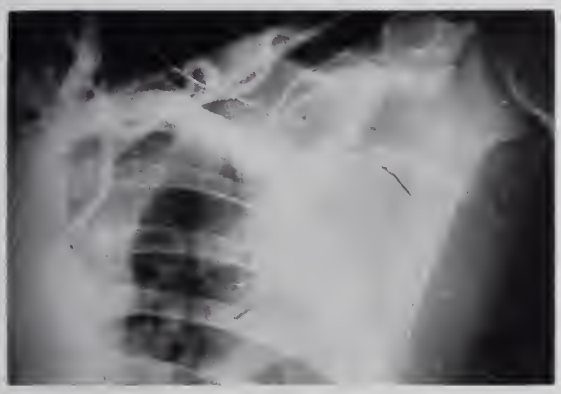


Figure 1

Left subclavian arteriogram using 70% Urokon through catheter inserted via superficial femoral artery. Site of false aneurysm of axillary artery is shown by arrow. Note filling of distal axillary artery.

nicely pinpointed the arterial rent beneath the pectoralis minor muscle where a spurt of contrast material into the false sac could be seen (Figure 1) and filling of the distal axillary artery shown.

Armed with this localization, further transfusions were given and the patient was operated upon on his fourth hospital day (September 1, 1959) and 11 days after his injury.

With the patient in a supine position, an S-shaped incision was made from the sternum along the medical two-thirds of the clavicle and into the left axilla. The medial half of the clavicle was removed and the sternum split to the 2nd intercostal space. An umbilical tape was passel around the left subclavian artery for proximal control and around the brachial artery to prevent back flow. The pectoralis major muscle was then divided and the clavipectoral fascia incised. The 4-inch diameter false aneurysm sac was entered and found to contain laminated clot with a ½-inch diameter cavity. It had practically replaced the pectoralis minor muscle, burrowing into the brachial plexus, axilla and pectoralis major muscle. There was a ¾-inch laceration of the axillary artery with a ¼-inch strand of posterior arterial wall preventing complete separation and holding the two ends open. The veins were intact but several were thrombosed. There was no obvious nerve damage although the tissue planes were gossly distorted. Both ends of the artery were mobilized and occluded with arterial clamps while an end-to-end anastomosis was constructed of 5-0 arterial silk using a continuous whip stitch interrupted at the corners. There was a small laceration in the apical pleura through which blood had entered the thoracic cavity. The sternum was reapproximated with #25 steel wire. There was pulsatile flow in the distal axillary artery as the wound was closed with fine silk. The patient received 1,500 cc of blood during the procedure which he tolerated well.

Postoperative Course

The immediate postoperative course was uneventful. The edema in the left arm subsided slowly but progressively and by the sixth postoperative day his hand was normal size with good function. The patient remained surprisingly free of pain and was fully ambulatory by the third postoperative day. On the seventh postoperative day he became febrile with an evening oral temperature of 103°F. His WBC was 5,400, Hct. 32, urine clear and chest unremarkable. The wound edges were opened but no fluid or pus was encountered. His unex-



Figure 2

Large rolled-up embolus removed from main pulmonary artery at autopsy.

plained fever continued throughout the next 24 hours but he was otherwise asymptomatic. Early in the morning of the eighth postoperative day he was accompanied to the bathroom by the nurse who found him dead on the commode 10 minutes later.

The pertinent autopsy finding was a long coiled embolus filling the main pulmonary artery. It was approximately the size of the innominate or axillary veins (Figure 2). The

femoral vessels were carefully examined and found to be patent and free of thrombus. The left chest was free of fluid with a thin fibrin layer. There was no pus or hematoma in the wound. The axillary anastomosis was intact. Death was ascribed to massive pulmonary embolization probably from the left arm.

Discussion

The initial problem in this patient was the treatment of a deep stab found in an area of critical vascular structures. His immediate course may be characterized by an enlarging hematoma and increasing venous obstruction. The time is past when such stab wounds can be legitimately watched.[2] The indications for exploration of any stab wound may be listed as: (1) *strong suspicion of penetration into abdominal cavity;* (2) *massive continuing or recurrent external hemorrhage* or evidence of internal hemorrhage; (3) *impending loss of distal limb viability;* (4) *major neurological deficit* and (5) *enlarging hematoma.* A sixth less obvious indication for exploration should be the *location of the penetrating wound* in an area of large vascular trunks, for example, the groin, axilla, supraclavicular area and root of the neck. Had this patient bled massively he would probably have received a life-saving immediate exploration of the wound site. Because of the lack of exsanguinating hemorrhage the optimum period of surgical intervention was lost.

The experience from treatment of vascular injuries in World War II, when ligation of lacerated arteries was the method of choice,[3] and the more recent experience from the Korean War, when primary repair was the recommended treatment,[1, 3] have underscored the major role of delay between injury and definitive treatment on the rate of extremity amputation. Where the elapsed time was under nine hours the amputation rate for both ligation and repair was less than one-half that of the 10-20 hour delay group. This is obviously a reflection of more than the arterial injury alone for serious associated injuries often prevented immediate transport of the patient to a vascular treatment station. Nevertheless, the time factor in prolonged ischemia to a damaged extremity is now uniformly accepted and underlines the need for decisive surgery.

Another important factor in limb survival is the extent of associated tissue damage which may necessitate extensive local debridement and thus compromise further the collateral circulation. Tourniquets have been justly condemned because their control of hemorrhage is directly dependent upon how effectively they stop collateral flow as well as the primary arterial flow.[1] Still another factor in limb survival is the anatomical location of the vascular injury. The wound of an artery in an area of poor collateral potential naturally decreases the chance of adequate perfusion of the extremity. The high incidence of amputation after ligation of the common femoral, popliteal and the proximal brachial arteries support this statement.[3]

Certain it is that immediate operation is not without predictable complications. Transection of vital collateral vessels must be avoided for a primary repair of the injured vessel may not prove possible. If lateral suture of the laceration or end-to-end anastomosis is accomplished thrombosis may occur at any time. The rate of wound infection in bruised hemorrhagic tissues will certainly be increased.

Even so, these possible operative complications do not approach the magnitude of the possible nonoperative problems. Indeed all three of these "operative complications" may occur under nonoperative management—collateral circulation may become inadequate with the expanding hematoma, thrombosis may occur in many of the traumatized vessels and the danger of infection from the penetrating knife blade or missile is ever present. To these must be added the lethal potential of secondary hemorrhage as well as the mortality and morbidity of the more difficult operative procedures for false aneurysms and arterio-venous fistulae.

The differential diagnosis between a large pulsating hematoma or false aneurysm of the axillary artery and an arterio-venous fistula in this patient was made on the basis of the loud systolic murmur without a disatolic component and the lack of distended veins in the area of the mass. This was confirmed by the arteriogram which was helpful in determining the most advantageous operative approach.

The unfortunate postoperative outcome in this patient was most likely secondary to preexisting venous thrombosis in the edematous, obstructed left arm. Whether extension of the thrombus occurred during or after operative procedure is an unanswered question. What is really important is whether the fatal emboliza-

tion could have been prevented. Ligation of the offending vessels would have removed this threat and, indeed, ligation of the left innominate vein was considered at the time of operation but was abandoned because of the fear of compromising further the already seriously obstructed venous return. The role of anticoagulants in such a large wound with open thoracic communication is a double-edged sword. It was not considered necessary to protect the arterial anastomosis with anticoagulants and so they were not added to the postoperative regimen.

This patient's injury, hospital course and postoperative death serve to emphasize the obvious conclusions.

Any penetrating wound of a major artery or into an area of large neurovascular structures requires immediate decisive surgical exploration and repair. Only by early suture of the arterial laceration or end-to-end anastomosis of the vessel can the serious sequelae of secondary hemorrhage, false aneurysms and arterio-venous fistulae be prevented.

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The Clinical Significance Of a Lump In the Throat

The sensation of a lump in the throat is a common complaint and is generally treated lightly, but to assume that it is purely functional without due examination in a given case is dangerous. The emotional lump in the throat is probably a spasm of the cricopharyngeus muscle, which is the lowermost portion of the m. constrictor pharyngis inferior and serves normally as the sphincter of the esophagus. The lump which moves up and down commonly represents the results of inflammation of the nasopharyngeal mucosa after influenza. The lump with aching is most often found in women and is associated with hypothyroidism. In the case presented, however, a lump that had been assumed at first to be functional in origin and later ascribed to chronic lingual tonsilitis, was ultimately found to be a squamous-cell carcinoma on the tongue at the level of the tip of the epiglottis. The discomfort connected with pharyngitis is not necessarily proportional to the extent of the pathological changes found on examination. The temptation to explain a lump in the throat as a form of neurosis should be resisted, and the physician should use all the means at his disposal to make a diagnosis and give appropriate treatment.

G. Edward Tremble, M. D., AMA Arch. Otolarygn., Aug. 1959

SPECIAL ARTICLES

Newer Diagnostic Services Of The State Department Of Health Laboratories

EMIL KOTCHER, SC.D.*

Louisville, Ky.

1. Philosophy of Laboratory Services

The Division of Public Health Laboratories of the State Department of Health was established to provide laboratory services to various professional personnel interested in the health of people. Such services are rendered by carrying out tests that detect biological or chemical agents which come in contact with people and cause them ill health. Most often the requests for such services originate with the personnel who are to be served. But occasionally, the laboratory scientist develops a test to detect such disease-producing agents. When this happens, he brings the significance of such a test to the attention of the appropriate personnel.

To serve the various personnel interested in the health of people, the laboratory is divided into two functional categories, viz.,

1. those functions that serve the sanitarian, sanitary engineer, food and drug control officers, water pollution control officers
2. those functions that serve the physicians, epidemiologist, public health veterinarians, nurses, etc.

The first group of functions involves the examination of food, milk, water, drugs, etc., by microbiological and chemical means. The second group of functions involves the examination of blood, sputum, feces, exudates, tissues, etc., by microbiological and chemical techniques for the detection of viruses, bacteria, fungi, protozoa, helminths, etc. Such agents are sought for in determining the etiology of acute infectious disease that may be prevalent in a community, so such diseases may be better controlled by immunization, isolation or other procedures. Some of these same microbiological and chemical techniques and other new techniques are also being used in detecting agents involved in chronic diseases.

2. Infectious Diseases

In regard to the acute infectious diseases, the following diagnostic services have been added to the list available at the Division of Public Health Laboratories.

a. Mycotic Infections:

Two types of serological tests for the detection of the systemic mycoses are available in our laboratory. A complement fixation test and a precipitin agar-gel diffusion test are being carried out in patients suspected of histoplasmosis, blastomycosis and coccidioidomycosis. As you all know, Kentucky is a hyperendemic area for histoplasmosis. As data accumulates, this may also be true of North American blastomycosis as well. The serological test is also available for coccidioidomycosis because patients may have visited and acquired the infection while in the endemic areas of the southwestern United States.

In addition to the serological tests for the mycoses, we can culture for these fungi either in artificial media or by animal inoculation. Special sputum containers having chloromycetin and cyclohexamide to suppress bacteria and non-pathogenic fungi may be obtained from the Division upon special request. Soil samples, chicken house, silo and cave dusts are also examined for *Histoplasma capsulatum* for epidemiologic investigations in an attempt to determine source of infection.

b. Bacterial Infections:

1. STAPHYLOCOCCAL BACTERIOPHAGE Typing—In view of the growing seriousness of hospital and community infections with penicillin-resistant *Staphylococcus aureus,* the Division is prepared to type strains submitted to it. Typing is done by subjecting the strain of *Staphylococcus* to twenty-four (24) types of bacteriophage that have been selected by the International Committee as the standard set of staphylococcal phages. The state laboratory will type only those strains of Staphylococcus aureus that are coagulase-positive and submitted to it in pure cul-

*Director, Division of Public Health Laboratories, Kentucky State Department of Health, Louisville, Kentucky.

ture. If such restrictions were not established, the volume of work coming in from hospitals and clinics all over the state would be too great with the funds available. In addition, with such restrictions it is hoped that the hospital and clinic laboratories throughout the state will appreciate the importance of providing adequate laboratory facilities and personnel to carry out a high quality of microbiology. Infection committees of hospitals should realize that the staphylococcal phage typing service is designed to provide epidemiological data to it so that the source of its difficulties may be found and eliminated, if possible.

2. EARLY DIAGNOSIS of streptococcal sore throat infections is being carried out by some physicians and public health nurses by providing them with blood agar tubes which permit them to determine if beta hemolytic colonies develop after being inoculated with throat swabs. Such a service helps them initiate penicillin therapy early in known rheumatic fever patients on a rational basis. While it is realized that not all beta-hemolytic colonies are streptococci, it has been found out that, in our series, about 15% of such colonies are streptococci.

3. WITH THE INCREASED INTEREST of physicians and public health workers in the aseptic meningitis and hepatitis syndromes, laboratory procedures which would reveal the etiologic agents of these syndromes have become very important. For this reason, leptospiral agglutination tests have been made available. Antigens of six species of leptospira are used in these tests. If the serum samples of patients with aseptic meningitis are negative for leptospiral agglutinations, the serum is tested by complement fixation tests against the neurotropic battery of viral agents. In this way a broader coverage of laboratory tests is given to the physician in helping him arrive at an accurate etiologic diagnosis. With such accurate etiologic diagnosis, a sound method toward therapy and public health control can be made.

In addition to agglutination tests for leptospira, cultural tests are also available on suitable specimens of blood or urine.

4. TWO NEW SEROLOGIC TESTS for syphilis have been added in recent months. One test, the rapid plasma reaction, is being used by field personnel of the Venereal Disease Control Section to screen out non-reactors. Individuals whose serum gives a positive reaction by the rapid plasma reaction are tested further by the VDRL test, inasmuch as the Rapid Plasma Reaction is somewhat less specific than the VDRL test. The virtue of the Rapid Plasma Reaction lies in its speed and ease.

The second test is the Reiter Protein Complement Fixation test which has been reported as being almost as specific and sensitive as the Treponema Pallidum Immobilization test. Because of the technical difficulties and the expense of the antigen, the Reiter protein Complement Fixation test is being done only on serum specimens on which there has been a request for a TPI test.

A third test for the serologic diagnosis of syphilis which will be added shortly is the fluorescein-tagged antibody procedure. This test is reported to have specificity and sensitivity approximating that of the TPI test. This test, however, will be run only on those sera whose VDRL results leave the physician in doubt as to the accuracy of the test, namely, those cases of biological false positives.

5. IN THE NEAR FUTURE, it is hoped that a satisfactory ultra-violet light source for fluorescent microscopy will become available so that fluorescein-tagged antibody procedures may be carried out in diagnosing such diseases as brucellosis, tularemia, toxoplasmosis, leptospirosis, and many viral infections. When such equipment becomes available, more rapid diagnostic aid can be given the physician and epidemiologist.

6. THE IMPORTANCE OF ANTIBIOTIC resistance developing in tubercle bacilli of patients under treatment has been recognized for some time. In order to help the staff members of the state tuberculosis hospitals, antibiotic susceptibility tests are being carried out when requested on strains isolated from patients who have been under prolonged treatment without showing the improvement that might normally be expected. In addition to such antibiotic susceptibility tests, virulence tests are carried out *in vitro* as well as in the guinea pig. There has been an increased recognition of the acid-fast organisms that are not *Mycobacterium tuberculosis,* yet which are isolated from patients with and without pulmonary lesions. A great deal of work has been done on the anonymous mycobacteria in an effort to elucidate their role in cases of pulmonary pathology.

c. Viral Infections:

The diagnosis of viral infections has been facilitated a great deal in late years by the discovery of procedures that can be carried out under not too expensive conditions. These procedures, namely, inoculation of tissue cultures, suckling mice, and chick embryos have made possible the isolation and identification of viral agents by state health department laboratories. Another important factor has been the ready availability of viral antigens for serologic tests through the private and Federal laboratories.

In regard to the isolation and identification of viral agents, our services tend to have a seasonal character. During the summer and fall, the virus laboratory has been concerned chiefly with the disease entities caused by the enteroviruses, namely, poliovirus, Coxsackie and ECHO viruses. These viruses have been isolated from clinical material obtained from patients with poliomyelitis, paralytic and non-paralytic, aseptic meningitis, pleurodynia, summer sore throat, and enteritis. During the present season, we have isolated and identified poliovirus I from a case of paralytic poliomyelitis, Coxsackie B3 and B4 and an ECHO 4 from cases of aseptic meningitis and enteritis. In addition to these definitely identified viruses, we have isolated several cytopahtogenic agents that have not been identified as yet. From July 1, 1958, to Febru-

ary, 1959, the following enteroviruses were isolated from clinical material of patients with the syndromes indicated:

No. of Cases	Virus Type	Clinical Specimen	Physician's Diagnosis
18	Polio I	Feces (18)	Polio (14) Aseptic Meningitis (3) Encephalitis (1)
1	Polio II	Feces	Polio
4	Polio III	Feces	Polio (3) Polio, non - paralytic
3	Coxsackie A-9	Feces (2) Spinal fluid (1) - c ECHO 18	Polio, Polio - like Aseptic Meningitis Encephalitis, aseptic meningitis
2	Coxsackie B-3	Feces (2) (1 - c ECHO 18)	Polio Encephalitis EE or St. L
2	Coxsackie B-5	Feces (2)	Polio Aseptic Meningitis

Our recommendations to physicians and health officers who are seeing patients with one or more symptoms that are related to the enteroviruses is to send us one or more specimens of feces obtained during the acute stage of illness, a spinal fluid specimen if there is neurological involvement, and blood specimens, the first during the acute phase of illness and the second during the convalescent period and at least three (3) weeks after the first specimen. Rarely, a request for a third specimen is made. The request for the two blood specimens is based on an attempt to demonstrate a rise in titer. A four-fold rise in titer is usually indicative of current infection. Isolation of an enterovirus from feces is not proof of the etiologic relationship between the virus and the clinical syndrome, inasmuch as such positive patients may merely be carriers of the virus. It is necessary to show an antibody rise in titer against the virus isolated from the feces to prove that the virus is responsible for the illness.

The success of the laboratory in isolating an enterovirus from feces, spinal fluid or throat washings is greatly enhanced if the specimens are shipped to us frozen with dry ice. This is especially true of spinal fluids and throat washings. However, if dry ice is unavailable, feces may be shipped unfrozen, inasmuch as the virus is known to survive in such material for at least 24 to 48 hours.

In regard to the aseptic meningitis syndrome, the various leptospira may also cause this illness. In view of the fact that these agents are frequently overlooked by physicians, all serum specimens submitted to us from such patients are also tested for presence of leptospiral agglutinius.

During the past year or two, an outbreak of arthropodborne encephalitis has not occurred in the state. We are prepared, however, to identify the viruses, e.g., St. Louis and Western encephalitis, producing this clinical entity by complement fixation tests. Our public health veterinarians are also on the alert for the increased prevalence of this disease in horses and mules.

During the winter and spring months, when the respiratory diseases are prevalent, requests for influenza, adenovirus, hemadsorption virus, etc., are made by physicians and health officers. We inoculate throat washings into embryonated hen's eggs in order to isolate the influenza virus, and cell cultures for adenovirus and hemadsorption viruses. Serological tests are carried out to identify and type the viruses isolated and to detect a rise in the patient's antibody titer. During the past winter, both influenza A and B were isolated from Kentucky patients. Several patients showed titers against the adenoviruses. As better tests are developed for the isolation and recognition of other respiratory viral agents, they will be adopted by the State laboratory.

The other viral infections for which diagnostic procedures, both isolation and serological, are available, are lymphocytic choriomeningitis, psittacosis, mumps, lymphogranuloma venereum, smallpox, vaccinia, chickenpox and herpes simplex. Unfortunately, there is not as yet a procedure available for determining the presence of the viruses that cause hepatitis.



Cooperation of Physicians and Clergymen in Pre-Marital Counseling

PHYSICIANS and clergymen have become increasingly aware of the importance of pre-marital counseling. Many Protestant Theological Seminaries include courses on pre-marital counseling. In addition, clinical training in this field is offered through programs like the Institute of Religion in the Texas Medical Center. An example of the interest of physicians in the field is *The Pre-Marital Consultation; A Manual of Physicians* by Drs. Abraham Stone and Lena Levine.

Although interest in pre-marital counseling has been growing among ministers and doctors, very little has been written about the actual cooperation of the two professions in this field. The purpose of this article is to acquaint physicians with the ways in which pastors may prepare couples to see a doctor and the ways in which physicians may cooperate with pastors in such referrals.

A minister may prepare an engaged couple for a visit to a doctor in several ways. First of all, he should have some personal acquaintance with the physician to whom a referral is being made. This personal knowledge of each other is important to the couple. They are reassured when the minister speaks of his confidence in their doctor. Furthermore, personal conversations will enable the two authorities to know something of the mutual beliefs on marriage. It is obviously confusing for the doctor and the minister to give conflicting advice to a couple. A good working relationship results from an accurate knowledge of the expectations which each has of the other.

Doctors can expect clergymen to emphasize the importance of a continuing relationship to a family physician. The pastor should urge them to think of questions which they would like to ask privately or together in the doctor's presence.

There are other reasons why a young couple should establish a good relationship with a physician. If one of them should become seriously ill in this city, they should know a doctor to call.

There are specific directions about the early days of their physical relationship which the couple can best discuss with their doctor.

The minister may discover some problems of guilt which are also important for the doctor's consultation. For example, a young woman may confess to her pastor that she has had pre-marital sexual relationships. She may ask the question whether her husband will know she is not a virgin? The pastor may discuss this with the young woman and help her to come to a decision so she will be in a better frame of mind to discuss this problem with her physician. A young man may confess to his pastor that he has had sex relationships with several women and fears that he may have a venereal disease. It is the pastor's responsibility to hear this man's confession and help him understand the relationship of sexual passion to marital fidelity. But he should conclude that section of the conference by urging his parishioner to discuss this fear of a venereal disease with the physician. Only the doctor can tell him, after examination, if he is infected.

These are some of the responsibilities of pastors in the preparation of couples to see a physician. Attention may now be given to some of the ways in which pastors would suggest that physicians cooperate with them in pre-marital referrals.

One of the first expectations is that the physician will have enough time to talk with the couple as well as examine them physically. Ministers recognize that the doctor's schedule is very heavy. But when a minister and doctor have agreed about their mutual responsibility in pre-marital counseling, it is hoped that the doctor will provide adequate time in his schedule for such consultation.

Secondly, a minister may expect to hear from a doctor when the couple presents some physical problem that needs spiritual counsel. For example, after the physical examination the physician may advise the couple to refrain from pregnancy. The couple may be quite disappointed in this and the doctor may sense that the wife feels guilty. He should inform the pastor of this and recommend to the couple that they seek spiritual counsel. There may also be the severe disappointment of the husband. He will need the minister's support and counsel concerning the possibility of parental fulfillment through church activities with children or adoption procedures.

The minister certainly should not expect the doctor to call him about every couple who is seen for referral. However, the professional relationship will remain active and productive if the doctor does remember to inform the clergyman about certain patients who have been referred to him. Otherwise, as Dr. Michael Balint has noted in *The Doctor, His Patient and the Illness,* vital decisions may be taken without anybody being fully responsible for them.

Thirdly, the minister expects the doctor to refer the couple's religious questions back to their spiritual advisor. In the case of interfaith marriage, there may be a good deal of tension about birth control. The couple should be advised to make up their minds about this with the help of their spiritual advisor.

Many problems of this nature are best handled through a mutual consultation. Each case will be a little different and will require some conversation between the doctor and the minister. It may take a few minutes now, but it will build an enduring professional relationship and contribute to the full development of young marriages.

Samuel Southard, Th. D.
Associate Professor
Psychology of Religion
Southern Baptist Seminary

Function of Tissue Committee Clarified

A bulletin of the Joint Commission on Accreditation of Hospitals, issued in August, 1959, clarifies the function of the tissue committee of a hospital medical staff.

This bulletin states, "Few persons question that the tissue committee, functioning properly, is one component of medical staff organization which has strengthened and improved the quality of medical care in hospitals. To be effective, committee reports are necessary and to insure their proper use, the hospital medical staff should make certain that this committee functions as an educational tool and not as a disciplinary device."

Physicians are individualists and many do not like the idea of another doctor or group of doctors deciding whether they have practiced good medicine. However, as the bulletin points out, "All physicians abhor incompentent or unethical work." When physicians practice and associate themselves together in a joint effort, such as a hospital medical staff, it is necessary to have definite rules and regulations in order to improve the surgical and medical care of patients. The doctor must "show willingness to both judge and to be judged."

The committee should have an educational influence and it should strive to see that antiquated or discredited procedures are done away with. It should also strive for the acceptance of the best methods of curing disease and treating patients. The patient then can be assured that in a hospital that follows these recommendations he will know that he will get the best of care.

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals suggests that in a typical general hospital the tissue

committee might be composed of "two surgeons, a gynecologist, an internist and a general practitioner. The pathologist is an ex-officio member of the committee." The medical librarian would give the tissue committee the tissue number, age, hospital number, pre-operative diagnosis, post-operative diagnosis, operative procedure and tissue removed. The pathologist would supply the pathological diagnosis and whether it was normal tissue. The committee would then decide whether the record indicated that the surgery performed was indicated.

The tissue committee should report to the executive committee each month. "After the executive committee has received and acted upon the report, the work sheets have served their purpose and the commission does not require that they be kept. It is assumed that members will respect the confidential nature of the work of the committee."

The bulletin again emphasizes that through this committee, with its educational responsibility, we can expect advancement of high quality patient care in our hospitals.

George W. Pedigo, Jr., M.D.



A Merry Christmas

and

A Happy New Year

Sam A. Overstreet, M.D., Editor
and
The Journal Staff

The J. L. Dismukes Memorial Meeting of the Kentucky State Medical Association

Roof Garden, Brown Hotel, Louisville, Kentucky, September 21-23, 1959
Digest of Proceedings of the Regular Sessions of the

HOUSE OF DELEGATES

Clyde C. Sparks, M.D., Ashland, Speaker of the House, Presiding

First Session

Doctor Sparks called the meeting to order and asked the Reverend Phillip G. Carpenter, pastor of Hershey Davis Baptist Chapel, to give the invocation. It was reported that a quorum was present. A motion that the minutes of the 1958 meeting be accepted as published in The Journal was made by Doctor Smith, seconded by Doctor O'Nan and the motion carried.

The Secretary made the general announcements, stating that the opening ceremonies would begin at 8:45 a.m. Tuesday in the Columbia Auditorium. He brought attention to the fact that there would be two specialty-group sessions this year instead of one, and also urged attendance at the President's Luncheon on Wednesday. He announced that the meeting places for the Nominating Committee would be designated at the close of this meeting, and that the seven Reference Committees would meet on Tuesday afternoon according to precedent. He recognized Doctor Frank Mayfield, President of the Ohio State Medical Association. Doctor Mayfield, he pointed out, would be remembered by many, having practiced in Louisville prior to moving to Ohio.

At this point, Doctor Troutman read the list of physicians who had died since the 1958 meeting. These physicians, their location, and date of death are as follows:

Amerson, S. S., Georgetown, May 2, 1959
Aud, Francis Guy, (Emeritus), Louisville, February 27, 1959
Baker, J. J., Cutshin, April 8, 1959
Barlow, E. C., (Emeritus), Georgetown, November 17, 1958
Barnhill, J. E., (Member), Owensboro, March 30, 1959
Blackwelder, Robert G., Hopkinsville, February 1, 1959
Blankenship, M. W., Fulton, October 17, 1958
Blanton, Harvey C., (Member), Richmond, April 20, 1959
Botkin, Daniel R., (Emeritus), Louisville, January 6, 1959
Boyd, Frank, (Emeritus), Paducah, September 27, 1958
Brallier, John S., Franklin, July 11, 1959
Brown, Greenberry B., (Emeritus), Georgetown, February 18, 1959
Brown, Oscar V., (Emeritus), Island, March 13, 1959
Bruner, Henry C., (Emeritus), Louisville, September 24, 1958
Bush, David H., (Emeritus), Mt. Sterling, November 7, 1958
Cain, William N., Lexington, October 30, 1958
Carman, John T., (Emeritus), Franklin, October 1, 1958
Coffman, John M., (Member), Owensboro, September 25, 1958
Cottingham, C. P., Uniontown, April 7, 1959
Crume, W. Keith, (Member), Bardstown, July 10, 1959
Dillard, Harry K., (Member), Lexington, October 9, 1958
Dodd, David W., (Member), Louisville, January 15, 1959
Dorsey, Thomas M., (Member), Louisville, February 13, 1959
Dudley, Will K., Hutchison, January 17, 1959
Fraley, Hugh B., Ashland, February 20, 1959
Frymire, E. W., Frankfort, October 9, 1958
Garvey, John F., Newport, September 20, 1958
Gerding, W. J., Newport, January 22, 1959
Gosnell, Thomas E., (Emeritus), Louisville, January 8, 1959
Gunn, William U., (Member), Harlan, September 16, 1958
Hale, Joseph G., Big Clifty, November 24, 1958
Hartman, John C., (Member), Campbellsburg, May 4, 1959
Heflin, Ernest L., (Emeritus), Louisville, June 19, 1959
Holbrook, J. H., (Emeritus), Paintsville, October 12, 1958
Hopkins, James C. (Col.), Hopkinsville, January 19, 1959
Ireland, R. Linsay, (Emeritus), Louisville, May 8, 1959
Jackson, J. A. C. (Col.), Winchester, August 5, 1959
Jackson, Elbert W., (Member), Paducah, November 28, 1958
Johnson, J. S., Wickliffe, 1958
Keen, E. J., Bowling Green, June 25, 1959
Kinnaird, Virgil G., (Member), Lancaster, January 11, 1959
Leet, H. Halbert, (Member), Lexington, January 26, 1959
McCormack, J. F., Verona, February 10, 1959
McKenna, Henry J., Louisville, October 8, 1958
Martin, Hallie E., LaFayette, January 17, 1959
Mason, Robert M., (Member), January 14, 1959
Maxwell, Elmer S., (Member), Lexington, January 9, 1959
Moore, W. B., (Emeritus), Louisville, September 20, 1958
Osburn, Roy, (Emeritus), Sebree, February 4, 1959
Osborne, William D., Bypro, June 22, 1959
Pennington, William H., (Member), Lexington, February 19, 1959
Rawleigh, George N., Paducah, February 13, 1959
Reps, Dewey H., (Member), Louisville, April 11, 1959
Rickman, Samuel M., (Member), Paris, May 21, 1959
Robinson, William C., (Member), Lexington, March 7, 1959

Shacklette, W. J., (Member), Hodgenville, June 7, 1959
Skaggs, D. G., Prospect, October 23, 1958
Solomon, Leon L., (Emeritus), Louisville, February 27, 1959
Summerville, William E., (Member), Louisville, November 11, 1958
Swetnam, Elmer, Lexington, March 7, 1959
Tanner, K. L., Covington, November 8, 1958
Terry, E. A. Jr., (Member), Louisville, October 26, 1958
Thompson, George L., (Member), Owensboro, August 10, 1959
Townsend, Robert G., (Member), Grayson, December 20, 1958
Van Arsdall, C. B., (Emeritus), Harrodsburg, October 25, 1958
Vaughan, Esther A. (Col.), Louisville, March 19, 1959
Wilson, George H., (Member), Lexington, September 26, 1958

The Speaker announced the Reference Committee appointments, subject to the approval of the House of Delegates, as follows:

Reference Committee No. 1—Reports of Officers and Councilors

W. Burford Davis, Louisville, Chairman
Loman C. Trover, Madisonville, Vice Chairman
Boyce E. Jones, London
James S. Williams, Nicholasville
John J. Rolf, Covington

Reference Committee No. 2—Reports on Medical Care, Medical Education, Hospitals and Related Subjects

W. C. Hambley, Pikeville, Chairman
Robert S. Tillett, Louisville, Vice Chairman
Gladys L. Rouse, Florence
Alex Spencer, West Liberty
C. R. Lewis, Georgetown

Reference Committee No. 3—Reports on Legislation and Public Relations

Russell L. Hall, Wheelwright, Chairman
Henry F. Chambers, Campbellsville, Vice Chairman
Robert B. Warfield, Lexington
Hubert C. Jones, Berea
Robert L. McClendon, Louisville

Reference Committee No. 4—Reports on Miscellaneous Business

Robert S. Dyer, Louisville, Chairman
Richard Rust, Newport, Vice Chairman
Robert W. Fidler, Flemingsburg
Donald Chatham, Shelbyville
William H. McKenna, Mt. Sterling

Reference Commitee No. 5—Reports on Miscellaneous Business

O. Leon Higdon, Paducah, Chairman
L. H. Segerberg, Louisville, Vice Chairman
Wilbur R. Houston, Erlanger
George E. Clark, Brandenburg
Willard Buttermore, Corbin

Reference Committee No. 6—Reports on Miscellaneous Business

N. Lewis Bosworth, Lexington, Chairman
Douglas H. Jenkins, Richmond, Vice Chairman
Harold Keen, Bowling Green
Billy J. Riddle, South Shore
W. H. Bryant, Glasgow

Reference Committee No. 7—Reports on Miscellaneous Business

Carl Cooper, Bedford, Chairman
L. Douglas Atherton, Louisville, Vice Chairman
Maurice Kaufmann, Lexington
Harry Denham, Maysville
Arthur Cooper, Somerset

Motion was made by Doctor Johnson, and seconded by Doctor Lynn that the Reference Committee appointments as made by the Speaker of the House be accepted. Motion carried.

The reports of the officers and committees were presented at this time and referred by the Speaker to the respective Reference Committee as follows:

Report of the President—Reference Committee No. 1, with the exception of parts dealing with the Jenkins-Keogh Bill and the benevolent fund, which were referred to Reference Committee No. 2.

At this point Doctor South presented a picture of the 1859 Kentucky State Medical Association President, Doctor Flint, to Doctor Robertson.

Report of the President-Elect—Reference Committee No. 1

Report of the Speaker of the House—Reference Committee No. 1

Report of the Chairman of the Council—Reference Committee No. 1, with the exception of the part dealing with compulsory vaccination, which was referred to Reference Committee No. 3.

Doctor Morse then read the following motion made by the members of the Council commending Doctor Sweeney: "The members of the Council of the Kentucky State Medical Association wish to commend the Chairman of the Council of 1958-59, to the House of Delegates for his excellence, fairness, and untiring sense of duty."

Glenn U. Dorroh, M.D., Chairman of the Awards Committee, presented the committee's nominations as follows:

Distinguished Service Award—Francis M. Massie, M.D., Lexington

Outstanding General Practitioner—Leland E. Payton, M.D., Lynch

Motions were duly made, seconded and carried that Doctor Massie be presented the Distinguished Service Award and Doctor Payton be presented the Outstanding General Practitioner Award.

Other reports were received and referred as follows:

Report of the Secretary — Reference Committee No. 1

Report of the Editor—Reference Committee No. 1

Report of the Treasurer — Reference Committee No. 1

Report of Delegates to AMA—Reference Committee No. 1, with the exceptions of the sections on Prepayment Plans and Relative Value, which were referred to Reference Committee No. 5, and the section on Cancer Quackery to Reference Committee No. 3.

Report of Executive Secretary—Reference Committee No. 1

Committee to Study the Constitution and Bylaws —Reference Committee No. 4

Committee on the Corporate Practice of Medicine —Reference Committee No. 4

Committee on Medical Education and Economics —Reference Committee No. 2

Medico-Legal Administrator—Reference Committee No. 5

Advisory Committee to the Editor—Reference Committee No. 6

Committee on Public Information and Service—Reference Committee No. 3

Committee on Physicians Placement Service—Reference Committee No. 7
Committee on Legislation—Reference Committee No. 3
Committee on Third Party Medicine—Reference Committee No. 3

Medicare Review Committee—Reference Committee No. 2
KSMA Advisory Committee to U. of K.—Reference Committee No. 2
KSMA Advisory Commission to Blue Shield—Reference Committee No. 5
Committee on Scientific Assembly and Arrangements—Reference Committee No. 2
Committee on Emergency Medical Services—Reference Committee No. 6
Committee to Study Relations with Voluntary Health Group—Reference Committee No. 5
McDowell Home Committee—Reference Committee No. 5
Committee on Rural Health—Reference Committee No. 7
Advisory Committee to Woman's Auxiliary—Reference Committee No. 6
Committee on Medical Services—Reference Committee No. 6
Committee on Allied Professions—Reference Committee No. 2
KSMA Representative to Conference of Presidents and other Officers of State Medical Associations—Reference Committee No. 5
KSMA Representatives on Joint Commission for Improvement of Patient Care—Reference Committee No. 7
KSMA Adviser to University of Louisville Student AMA Chapter—Reference Committee No. 6
KSMA Representative on State Practical Nurses Advisory Committee—Reference Committee No. 7
KSMA Representative on State T. B. Coordinating Council—Reference Committee No. 7
Board of Directors of the Kentucky Physicians Mutual, Inc.,—Reference Committee No. 5
Rural Kentucky Medical Scholarship Fund—Reference Committee No. 7
Advisory Committee to Selective Service—Reference Committee No. 4
Professional Relations Committee—Reference Committee No. 2
Report of Woman's Auxiliary—Reference Committee No. 6

New Business

The new business was then presented to the House and referred to Reference Committees by the Speaker, as follows:

(A) Resolution of the Muhlenberg County Medical Society concerning the KSMA naming a three-man ad hoc committee to study the feasibility of KSMA having its own building—Reference Committee No. 1

(B) Resolution of the Jefferson County Medical Society concerning a Kentucky Constitutional Convention—Reference Committee No. 3

(C) Resolution of the Advisory Committee to Blue Cross concerning unnecessary admissions to hospitals and unnecessary prolongation of hospital stays—Reference Committee No. 5

(D) Resolution of Fayette County Medical Society concerning amendments to Bylaws—Reference Committee No. 4

(E) Resolution of the President expressing gratitude to Postmaster General Summerfield for his willingness to authorize the issuance of the McDowell Stamp—Reference Committee No. 1

(F) Resolution of President concerning the Apothecary Shop—Reference Committee No. 1

(G) Resolution of President expressing gratitude to the Senators and their staffs for the contributions made concerning the McDowell Stamp—Reference Committee No. 1

(H) Resolution of the Allen County Medical Society, opposing the service-type plan for any age group—Reference Committee No. 5

(I) Resolution of the Allen County Medical Society concerning interim meeting of the House of Delegates—Reference Committee No. 5

(J) Resolution of Harlan County Medical Society concerning immunization—Reference Committee No. 3

(K) Resolution of John W. Meredith, M.D., concerning the corporate practice of radiology and pathology by hospitals—Reference Committee No. 3

(L) Resolution of Spencer County Medical Society asking that Spencer County be transferred to the Seventh District—Reference Committee No. 4

The Speaker then designated meeting places for th Nominating Committee for General officers and the five Councilor Districts Nominating Committees to be held immediately at the close of this session. He also announced that Tuesday morning at the close of the first scientific session, the Nominating Committee would make known its recommendations for the various state offices. Doctor Sparks reminded the members of the House that on Wednesday evening, after these nominations were read, additional nominations might be made from the floor without discussion.

Doctor Sparks then expressed appreciation to the members of the House for their attention during the evening.

There being no further business a motion was duly made, seconded and carried that the meeting adjourn at 9:40 p.m.

Clyde C. Sparks, M.D.
Speaker of the House of Delegates

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Second Session

The Second Session of the Kentucky State Medical Association House of Delegates was called to order on Wednesday, September 23, 1959, by the Speaker, Clyde C. Sparks, M.D., in the Roof Garden of the Brown Hotel, Louisville, at 7:10 p.m. The invocation was given by the Reverend Kenneth G. Pfifer, of the Louisville Presbyterian Seminary, after which the Credentials Committee reported a quorum present.

The Speaker of the House of Delegates stated that he would now appoint two teller committees as follows: Paul E. Lett, M.D., Lancaster; George F. Brockman, M.D., Greenville, and C. V. Dodson, M.D., Russellville, as Tellers on Committee No. 1; and A. B. Colley, M.D., Owensboro; R. A. Hamilton, M.D., Springfield, and Robert D. Shephard, M.D., Lexington, as Tellers on Committee No. 2.

Garnett J. Sweeney, M.D., Chairman of the Council, presented the final report of the Council as follows:

The Council submitted the following resolution passed at its September 23 meeting as its final report:

"WHEREAS, The 1959 KSMA Annual Meeting has been well received and has made a substantial con-

tribution in the field of postgraduate medical education, and

"WHEREAS, many individuals, organizations, and agencies, including guests and state essayists, technical exhibitors, newspapers, radio and television stations, hotels, and the Auditorium, have contributed to its success, and

"WHEREAS, members of the faculty of the University of Louisvile School of Medicine have cooperated whole-heartedly in the setting up and presentation of this program, now

"THEREFORE BE IT RESOLVED, That this House of Delegates go on record as expressing its deep appreciation to all who have had a part in the development and implementation of the 1959 Annual Meeting."

Mr. Speaker, I move the adoption of this resolution. The motion was duly seconded and carried.

The Secretary made the general announcements, stating that a very good program was scheduled for the following day with specialty groups meeting in the morning and the general session in the afternoon. He also reminded the members of the House of the University of Louisville's Alumni Dinner to be held the following evening at 6:30 p.m. He then recognized H. L. Monroe, M.D., of the Tennessee State Medical Association, and Mr. James Waggoner, Executive Secretary of the Indiana State Medical Association.

The reports of the Reference Committees were then presented.

REFERENCE COMMITTEE NO. 1

W. Burford Davis, M.D., Chairman
Reports of Officers and Councilors

The Report of the President

Watching the KSMA grow and expand its services to its members and to the people from the vantage point of the president-elect and the presidency the last two years has been a privilege—for which I am very thankful—and an inspiration. For me, it has been a very busy two years.

I have attended most of the Councilor District meetings, a number of out-of-state meetings in which I have represented the Association and have made dozens of trips to Louisville and other points in Kentucky on KSMA business. Some of my patients in Paducah think I have opened an office in Louisville, too!

While the experience of being president has been most enjoyable, it has indeed been a sobering one. Socio-economic problems facing medicine seem to multiply faster than organized medicine can find the answers. Your Officers, Council and Committees have accomplished much at the state level in the last two years—what has been done is most heartening. As you have read through your House of Delegates Envelope for this 1959 meeting, you will find that this statement is completely borne out.

You know you just cannot serve as President of this vast organization a year and not see numerous opportunities that should be taken advantage of and needs that should be filled by our Kentucky Medical Profession. You may not agree with all of them, or you may feel that they should be accomplished in some manner other than those suggested. At any rate, I hope this House will give careful consideration to the following recommendations.

The year of 1960 will be a crucial one for medicine in the field of legislation, especially at the national level. Final action will be taken on the give-away Forand proposal (HR 4700) to amend the social security act. You can be sure that labor and the multitude of proponents for more government control and spending will put up a formidable fight to pass the legislation. Kentucky physicians need every possible contact in Washington with its lawmakers because of this and other matters. Having attended the 1959 KSMA dinner in Washington, honoring our congressmen and senators, and seeing the benefit that comes to all parties concerned, we would strongly recommend to this House of Delegates that the practice of holding the dinner in Washington be continued for the immediate future, at least.

In our travels, it has become increasingly evident that adequate medical care of our senior citizens is one of the most important problems medicine is facing today. Your KSMA Advisory Commission to Blue Shield is working on this problem and will have a report for you. Your KSMA Committee on Problems of Aged is also active and will report to you. Specifically, I would like to ask this House to urge every organized County Medical Society in this state to actively consider this problem of adequate medical care for the aged and take every possible measure to fill its responsibility in what ever manner the local county society elects.

While the future of the Keogh-Jenkins type legislation at this writing has not definitely been determined, it would appear that this Association should have some well-defined plan to take advantage of the benefits from such legislation, if enacted. We would, therefore, recommend that the House of Delegates authorize the KSMA Committee on Medical Economics and Education to study this bill carefully and be ready to make recommendations to the Council of KSMA on or before the 1960 County Society Officers Conference.

Our patients are demanding more and more, and understandably so, that medicine provide for them a more accurate and effective plan for budgeting and the prepayment of medical expenses. We would like to urge our members and the Council to try to consider carefully and thoughtfully some plan which would be of the greatest benefit to the people and also acceptable to the profession. If we don't take care of our people in this direction, we must accept the consequences. However, let me urge that we do not get divided over any issue that is not favored by the majority of our members.

In my travels during the past year, I have noted a growing interest among KSMA members in the matter of KSMA building a new home to house the Headquarters Office. Some of our members who have been to neighboring states which have their own homes have returned to Kentucky and are enthusiastic in their feeling. We too should look into the matter. I would like to point out our present quarters are inadequate and no space adjacent to our office is open in the foreseeable future. There are no facilities for further expansion. When we moved to our present quarters in 1957, the expanded services voted by this body in 1958 were not anticipated. Having a substantial, conservatively built and well located office would let the people of our state know that we are "in business for keeps," that we are a service organization that accepts and takes our responsibility seriously. It would contribute greatly toward establishing our organization as a positive force for the improvement of the welfare of the people we serve. With this in mind, I recommend to this House that it authorize the new Executive Committee of the Council to name a three-man committee to study this matter and report to the 1960 meeting of this House. I would include in this recommendation that this committee study among other things the matter in which our sister states financed the construction of their new homes, and that at least two states who have recently built new homes be visited by this committee for firsthand study.

To date the need for a benevolent fund to take

care of physicians and their family with acute or emergency financial problems in Kentucky has not been widespread. A number of state medical associations have such a fund, others are contemplating it. There does seem to be reasonable argument that the medical profession should be in a position to take care of its own who are in need. With this in mind, I recommend that the House of Delegates authorize the Speaker to appoint a special committee to study this matter, looking into the need, the manner in which distress fund might be financed, etc., and report back to the House at the 1960 meeting.

I am looking forward to discussing with you briefly during the general session in the morning, in a broader sense, some of the matters we feel deserve our most serious consideration.

I want to thank one and all for the splendid cooperation that the members of KSMA have given my administration. I am deeply grateful for the consideration the House of Delegates has shown me, as have the Council, Executive Committee and officers of the Association. It has been a real pleasure to work with all of you.

I could not allow this occasion to pass without making some reference to Joe Sanford and his staff at the Headquarters Office. Without their untiring efforts no doctor could successfully fill the office of President of the KSMA.

I would like to thank each member of the Headquarters Office for his instinted support and cooperation.

Yes, my year as your President produced its highlights and I shall enjoy recalling them for years to come.

Robert W. Robertson, M.D., Paducah
President

Recommendations, Reference Committee No. 1

The Report of the President was approved with the exception of the last paragraph of page 2 and the first paragraph of page 3, relating to the Keogh-Jenkins type legislation, which was referred to Reference Committee No. 2.

The Committee heartily endorsed the recommendations of the President. We should like to commend the President for his diligent efforts in behalf of the Association during his term of office.

Mr. Speaker, I move the adoption and implementation of this section of the report.

The motion was seconded and carried.

A motion was made and seconded that the President's Report be approved except for that portion concerning the recommendation that a committee be appointed to study the possibility of building a new KSMA Headquarters Office. This motion was defeated.

Report of The President-Elect

Since September of 1958, I have attended, during February, the KSMA dinner in Washington honoring the Congressmen from Kentucky; during June, the Annual Meeting of the American Medical Association in Atlantic City, and during August, the Annual Public Relations Institute sponsored by the American Medical Association in Chicago. I have been at meetings of the Executive Committee of the Council, meetings of the Council, and such other KSMA Committee meetings as are a part of the duties of the President-elect. It has also been my pleasure to, at the request of the President, represent him at several meetings here and elsewhere in the state.

I am deeply appreciative of the assistance, suggestions, and counsel which have been freely and generously offered to me from all sources within this organization.

Irvin Abell, Jr., M.D., Louisville
President-elect
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The report of the President-Elect was unanimously approved. It was noted that Doctor Abell has been extremely active in representing KSMA during the past year.

Mr. Speaker, I move the adoption of this report.

The motion was seconded and carried.

Report of The Speaker

The duties as outlined in the Bylaws, etc., with the assistance of the Vice-Speaker and the Headquarters Office, have been carried out during the past year.

One special meeting of the House of Delegates was held and the conclusions reached are a matter of record.

The meeting place has been changed to provide better facilities for the delegates and additionally a copy of the Reference Committee reports will be available to each delegate prior to the final session.

It has been a pleasure, a privileged duty, and an honor to serve you as presiding officer during the past three years. It is my considered opinion that the Speaker should be a presiding officer and not allow his personal wishes to influence any decision the House should be making. This I believe is essential in choosing my successor.

For your many kindnesses and cooperative efforts over the years I shall always be grateful.

Clyde C. Sparks, M.D.
Speaker of the House of Delegates
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The report of the Speaker of the House was enthusiastically approved.

The Committee would like to commend Doctor Sparks highly for his consistent excellence in leading and directing House activities. His fairness and efficiency are exemplary.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Council

Your Council has been called upon to make many important decisions during the past year on behalf of our membership, many of which will also have a direct bearing upon the health and welfare of the people we serve. Time will judge the correctness of our efforts.

Many members of your Council feel that we in medicine must inform ourselves more thoroughly on the problems—socio-economic and political—facing medicine today, and seek to solve these problems after realistic and full consideration in a bold and forthright manner. Unless this is done, we must accept the consequences that inevitably befall those who temperize.

It seems appropriate in this report to you, the members of the House, to give you a few facts on the contribution in time and effort (and we might add in financial sacrifice). Members of the Council attending a single meeting of the Council will drive approximately 5,000 miles and spend 310 "doctor hours" serving their colleagues and the people of Kentucky.

There have been four meetings of the Council and three meetings of the Executive Committee of the Council during the past year. Minutes of meetings of these two bodies are on file in the KSMA Headquarters Office and may be viewed by any member at any time.

Highlights of the actions of the four meetings during the 1958-59 Associational year follow:

FIRST MEETING: The organizational meeting of

the new Council for the 1958-59 associational year met Thursday, September 25, on the last day of the Annual Meeting, at the Brown Hotel. The Council was called to order by the temporary chairman, Garnett Sweeney, M.D., of Liberty, Kentucky. When nominations for Chairman were called for, for the coming year, the name of Doctor Sweeney was offered by Doctor Pace, a second motion to the effect that nominations cease was passed and Doctor Sweeney was elected the chairman.

New members of the Council were then recognized. They were: Irvin Abell, Jr., M.D., Louisville, President-elect; Thomas O. Meredith, M.D., Harrodsburg, Vice-President, Eastern District; Lillard F. Beasley, M.D., Franklin, Vice-President from Western District; (Marvin Lucas, M.D., Vice-President, Central District, Louisville, was not present); Delmas Clardy, M.D., Hopkinsville, Treasurer; Wyatt Norvell, M.D., New Castle, Councilor from the Seventh District, and Richard G. Elliott, M.D., Lexington, Councilor from the Tenth District.

The Chairman then welcomed back to the Council Woodford B. Troutman, M.D., as Secretary and Councilors Walter L. O'Nan, M.D., Henderson, J. M. Stevenson, M.D., Brooksville and Charles Johnson, M.D., Russell, all re-elected incumbents.

Carlisle Morse, M.D., was selected as Vice Chairman of the Council. The Council then proceeded to form the Executive Committee. Automatically on the Executive Committee are the Chairman, the Vice-Chairman, the President, President-elect and the Secretary. The remaining two members are Councilors which are elected. Those chosen were J. Vernon Pace, M.D., Paducah, and Norman Adair, M.D., Covington.

It was decided that the Chairman of the Council, the Secretary and the President would be selected as the nominating committee to choose members of the Committees appointed by the Council. After these members had been selected, the names would be sent to the members of the Council for approval.

John D. Gordinier, M.D., Louisville, was reappointed for a three-year term as Medico-Legal Administrator.

SECOND MEETING. The Council held its second meeting in the Brown Hotel on December 11, 1958.

The Chairman of the Council called the meeting to order, thanked the members for their attendance along with a note of welcome for the guests, and requested Mr. Grogan to introduce William E. Rudd, the new Executive Assistant of the Association.

Minutes of the September 22, 24 and 25 Council meetings were adopted as mailed. The President reported on his attendance at the December 4, 1958, Rural Health Conference and read a proposed list of twenty-one members to serve on an Advisory Commission to Blue Shield from KSMA.

The delegates to the interim meeting of the AMA held in Minneapolis gave a full report on the main issues and objectives discussed at this meeting including some of the problems that medicine is facing and the providing of active leadership in solving this issue. The Council authorized the Executive Secretary to send a letter of appreciation to Vincent Askey, M.D., Los Angeles, Speaker of the AMA House of Delegates, for his cooperation in securing the passage of a commemorative stamp for Ephraim McDowell-Jane Todd Crawford 150th anniversary of the first successful oophorectomy. The Council accepted a recommendation that a four-man committee be appointed and that $1,000 be set aside to defray expenses of KSMA committee chairmen attending national meetings of special interest. This committee would "screen" the meetings to determine if KSMA should be represented.

The Headquarters Office report was presented by the Secretary, who called particular attention to the second annual dinner for Kentucky's congressmen and senators to be held in Washington, February 26, 1959.

Comments were heard from the Commissioner of Health who also read a recommendation by the AMA in regard to poliomyelitis inoculation. This program was discussed and the Council approved the recommendations of the AMA House of Delegates and instructed the Headquarters Office to mail the recommendation and steps to be taken to all county medical societies.

The Chairman called the attention of the Council to the stand taken recently by Jefferson and Taylor Counties in admonishing a member of their respective societies. The Council then authorized Headquarters Office to send a letter to these two societies commending them on their actions.

It was agreed by the Council that the County Society Officers Conference be held in Owensboro in 1960 on a trial basis for that year only.

Garnett J. Sweeney, M.D., Liberty, Chairman of the Council, stated several difficulties had been encountered in securing participants and that it had been necessary to revise the recommendations which were approved November 6 by the Executive Committee. After discussion, the Council approved the following program and participants:

(1) Ernest B. Howard, M.D., Assistant Executive President of the AMA, who will present an overall review on Forand type legislation.
(2) Donald Cass, M.D., Chairman of the Professional Relations Committee of Los Angeles County Medical Association, who will give a talk on medical societies policing themselves,
(3) Leslie Hodson, anti-trust lawyer for the AMA, who will participate in a panel discussion on third party medicine with Hugh W. Brenneman of the Michigan State Medical Association and the Michigan Bar Association serving as moderator,
(4) A luncheon session with Russell Roth, M.D., presenting his illustrated lecture on medical public relations.
(5) Final presentation to be by Donald Stubbs, M.D., of the National Blue Shield Commission.

The appeal of Allyn F. Judd, M.D., Whitesburg, was discussed at length and was not accepted. The Council approved the holding of an open meeting in the summer, to which meeting all KSMA members will be invited.

Carl Cooper, Jr., M.D., Bedford, and Russell E. Teague, M.D., Commissioner of Health, Louisville, presented information on the formation of the Kentucky Health Council along with its objectives. It was stated this body will be a coordinating body with an aim of providing means for joint planning, for all agencies concerned with health, to study these needs, and to arouse public interest in these needs. It was pointed out that the Kentucky Health Council is not a branch of the National Health Council and with unity of several organizations the health interest of our Commonwealth could best be served. After a thorough and lengthy discussion the Council decided to appoint a committee to study the objectives and other matters relating to the Kentucky Health Council and to report their findings to the Council at its next meeting. Doctor Cooper, Chairman, Branham B. Baughman, M.D., Frankfort, and Walter L. O'Nan, M.D., Henderson, were then named to this committee.

Edward B. Mersch, M.D., Covington, Chairman of the KSMA Committee on Third Party Medicine, stated his committee had no definite announcement on the solution to the problem due to the complexity and wide scope involved; that he and the committee were hoping to come up with an acceptable plan but it could take considerable time.

Instructions were given to the Committee on Third Party Medicine to secure information, when necessary, from local sources in problems relating to physicians in practice, and to so use this information as a basis in determining if the physician meets the re-

quirements in the area for the type of practice applied for.

Permission was granted by the Council to the KSMA President to call a special session of the KSMA House of Delegates if circumstances so warrant.

Adopting the KSMA Committee on Legislation's recommendations that the Legislative program on the state and national levels be expanded, the Council then approved the reimbursement of legislative key men for emergency phone calls if the key men so elected to be reimbursed. It was also decided by the Council to furnish each legislator, both on the state and national level, a subscription to the "AMA News."

The Council voted to re-introduce the Quick Cremation Bill into the 1960 State Legislature.

Robert D. Shepard, M.D., and Robert B. Warfield, M.D., both of Lexington, were appointed to serve on the Legislative Committee as representatives from Fayette County. The Council then went on record to recommend asking all county medical societies to entertain their respective legislators and also invite them to councilor district meetings, along with Mr. Grogan, Director of Field Services for KSMA.

In connection with the change in the fee schedule for the Veterans Hometown Medical Care Program, it was adopted that any changes in the fee schedule be left to the Committee on Federal Medical Services.

The Council authorized the purchase of two copies of the film, "The Medicine Man." These copies will be used by the State Department of Health in its lending library with full credit going to KSMA. The short form insurance claim blank which has been revised was adopted by the Council and will soon be made available.

It was voted that the editor of "Kentucky Business," which is published by the Kentucky Chamber of Commerce, be written a letter of commendation for the articles on the Rural Kentucky Medical Scholarship Fund and Great Medicine in the December, 1958 issue. There being no further business, the meeting was adjourned at 3:10 P.M.

THIRD MEETING. The third meeting of the Council was held at the Brown Hotel, Louisville, Kentucky. Garnett Sweeney, M.D., Liberty, chairman, called the day-long meeting of the Council to order on Thursday, April 2. Minutes of the December 11, 1958, meeting were adopted.

The President reported that he had attended the County Society Officers Conference, a special meeting of the House of Delegates, a conference on Third Party Medicine, and had spoken at Senior Day and at the Ninth Councilor District meeting.

The Headquarters Office report was presented by the Secretary. The report showed that the Senior Class at the University of Louisville School of Medicine was very grateful for the Association's efforts at Senior Day. It was stated that 151 had registered for the County Society Officers Conference in Lexington. Among other activities, the Headquarters Office was promoting meetings for eight Councilor Districts.

The Council was informed that Thomas B. Leonard, M.D., Frankfort, had resigned as chairman of the Legislative Committee and that his resignation had been accepted by the Executive Committee with regrets. Wyatt Norvell, M.D., New Castle, was elected to serve as temporary chairman of the Legislative Committee for State Affairs, with Doctor Leonard serving as temporary vice-chairman.

Gaithel L. Simpson, M.D., chairman of the KSMA Committee on Medical Education and Economics, was recognized and explained that as directed by the 1958 House of Delegates his committee had prepared a proposed bill for indigent medical care. After the proposed bill was explained, it was approved by the Council with the understanding that it would be sent to the Allied Council on Medical Services for further consideration prior to its presentation to the Legislature.

The Council voted to defer taking a poll on the subject of compulsory Social Security for physicians. After discussion it adopted a recommendation of the Committee on Scientific Assembly and Arrangements that a $50 honorarium be paid guest speakers participating in the scientific program of the Annual Meeting.

Walter S. Coe, M.D., Louisville, chairman of the KSMA Committee on Postgraduate Medical Education, reported on the activities of his committee. It was agreed that the money set aside in the budget for this committee's use would be made available when a definite plan is submitted by the committee to the Council and is accepted.

Ralph D. Lynn, M.D., Elkton, chairman of the Budget Committee of the Council, explained the 1959-60 proposal which was unanimously accepted by the Council.

After the seven recommendations of the Committee on Problems of the Aged were considered by the Council, the Headquarters Office was authorized to send copies of the recommendation to all county medical societies and all hospital staff secretaries. It was the feeling of the Council that the seven-point program would stimulate activity at the local level in meeting the problems of the aged.

The Council authorized Woodford B. Troutman, M.D., Louisville, secretary of the KSMA, to determine whether or not the Association should support the forming of a new joint council to improve the health care of the aged at the state level or to recommend that the Council on Allied Medical Services take over this function in addition to the other activities it carries on.

George W. Pedigo, M.D., Louisville, associate editor of the Journal of the KSMA, presented a proposal for a new cover for the Journal. The recommendation which was made by the Editor and his Advisory Committee was accepted by the Council. Following the report on the Southeastern Editors Conference, Doctor Pedigo was authorized to explore the possibilities and costs of holding the 1960 Conference in Louisville.

Following a report by Delmas M. Clardy, M.D., Hopkinsville, chairman of the KSMA Advisory Committee on Public Health, the Council voted to:

1. Recommend compulsory vaccination for diphtheria, pertussis, tetanus, and polio for all children prior to entrance in grade school.
2. Offer the Department of Public Safety in Frankfort the KSMA's assistance in combatting the tragic loss of lives in highway accidents.
3. Give publicity, in the interest of public health, to the facilities available for detection of cancer of the cervix.
4. Officially endorse fluoridation in Kentucky.
5. Take no action on the question of cigarette smoking and its relation to lung cancer.
6. Follow the practice of the U.S. and Kentucky Public Health Departments in the use of BCG vaccine, inasmuch as it is of a controversial nature.

Carl Cooper, M.D., Bedford, reported for the committee that had been appointed to work with the proposed Kentucky Health Council. A proposed amendment to the Health Council bylaws offered by Doctor Cooper was approved by the Council.

Doctor Cooper also brought the recommendations of the Committee on Public Information and Service of which he is a member. The recommendation that KSMA sponsor a luncheon for new members on Tuesday of the Annual Meeting was accepted. The Council authorized the Committee to carry out the program it had proposed for the dissemination of information on Third Party Medicine. In addition, the Council, after discussion, established the procedure for the release of news items to the press on activities of KSMA Committees.

Russell E. Teague, M.D., Commissioner of Health, reported that the State Board was considering the possibility of modifying the Medical Practice Act in Kentucky so that certain foreign physicians approved by the Educational Council for Foreign Medical Graduates might be licensed. He also said that consideration was being given to amending the Medical Practice Act, making it mandatory that an annual registration of all physicians be carried out. The registration fee would be two dollars per physician.

The Chairman of the Council explained that it was customary for the Council to have an open meeting each year, and July 30 was set as the date for the 1959 open meeting. It was decided to have the 1960 County Society Officers Conference on Thursday, April 7, at Owensboro, Kentucky. The 1962 Annual Meeting to be held in Louisville was scheduled for September 18, 19 and 20.

After lengthy discussion, the Council requested the KSMA Advisory Commission to Blue Shield to work with the Blue Shield staff to bring forward a proposed plan for providing coverage on a full-payment plan for the people of Kentucky. The Commission was asked to be in a position to report by July 30.

To strengthen the machinery for arbitration of grievances, the Council decided to form a grievance committee for each councilor district. The Chairman of the Council was authorized to appoint as chairman of each district the Councilor for that district with two Councilors from adjoining districts making up the balance.

FOURTH MEETING. The open meeting of the Council was held on Thursday, July 30 at the Brown Hotel, in Louisville.

The report of the President, the Secretary and the Delegates to the AMA were presented (See August issue of the Journal for a detailed account of the AMA Annual Meeting of the House of Delegates in June, 1959.)

The Legislative Committee report was given by the Chairman for State Affairs, Wyatt Norvell, M.D. He stated that apparently the Forand Bill (H.R. 4700) was shelved for this session of the Congress, and that the efforts of Carl Fortune, M.D., in testifying before the House Ways and Means Committee on July 17 had been effective. The new legislative key man system was explained and praise was given J. Farra Van Meter, M.D., Lexington, for his work in connection with resisting the Forand Bill. The meeting with the gubernatorial candidates earlier in the week was also described by Doctor Norvell.

Status of the indigent care legislation was described by Doctor Troutman. It was pointed out that all members of the Council on Allied Medical Service had agreed on an indigent care bill and that the proposal was now being reviewed by the Legislative Research Commission.

The Council then decided to support legislation that would provide funds for compulsory vaccination and referred a request for a study on privileged communications to a special committee.

The report of the Committee on Postgraduate Medical Education was given by Walter Coe, M.D. It was pointed out that part of the increase in dues voted by the 1958 session of the House of Delegates had been earmarked for the postgraduate medical education program. This was voted after this Committee, a year ago, had presented a proposal estimated to cost approximately $10,000 a year.

Doctor Coe said that present plans call for the getting of a full-time coordinator, a secretary and the opening of an office. The University of Louisville and the University of Kentucky are cooperating substantially with the project. The Council voted to implement the program and make the necessary funds, not to exceed $10,000, available.

The question of whether relative value studies should be conducted in this state was debated at some length and it was eventually decided to send the necessary information to local county medical societies and ask that the societies report on the desirability of whether or not the KSMA should conduct such a study.

The report of the KSMA Advisory Commission to Blue Shield was presented by W. Vinson Pierce, M.D., chairman of the Commission. It was pointed out that his Commission had been asked to prepare a special contract for the aged and also to develop a service type coverage for consideration by this Council. Actual presentation of the Commission's recommendations was made by Mr. Don Giffen of the Kentucky Blue Shield Plan at the request of Doctor Pierce. Following a lengthy discussion, it was decided to distribute more information on the pros and cons of service type coverage and consider at a special meeting of the House of Delegates following the Annual Meeting.

Immediately after this action was taken, the Council authorized the KSMA Advisory Commission to Blue Shield to proceed with the development of a special indemnity type old age coverage for implementation.

Following comments by the Commissioner of Health, the Council voted to ask the Legislative Committee and the Association's attorney to review the Medical Practice Act, with respect to making adjustments in connection with the limited license provision. The Council heard a request from the Gibbs Inman Company for an increase of 5% in billing to the Association for printing the Journal. It was felt that this increase was indicated due to rising labor costs and paper charges. The Council voted to grant the increase.

The suggestion that the KSMA invite the 1960 meeting of the Southeastern Medical Editors Conference to Louisville was approved. The request of the Medicare Review Committee that the Committee's make-up be slightly revised was approved and the Council accepted the change in bylaws of the proposed Kentucky Health Council.

It is a pleasure to report to you that the Postmaster General has authorized the issuance of a special "famous persons" commemorative stamp honoring Dr. Ephraim McDowell and his famous operation, which was performed on Christmas Day, 1809. The maroon on white stamp will be issued at Danville in December this year.

The effort to get the stamp began in December of 1957, when the Council granted permission to the Executive Secretary to investigate the matter on the occasion of the first KSMA Congressional Dinner in Washington. Since that time, 18 national, regional and state organizations have passed resolutions asking the Postal Department to issue the stamp.

Garnett J. Sweeney, M.D., Liberty
Chairman
Council of KSMA

Recommendations, Reference Committee No. 1

The Report of the Council was considered in great detail and approved, excepting page 9, item 1, referred to Reference Committee No. 3.

The Committee feels it would be desirable to have a more detailed plan for postgraduate education. We wish to commend the Council on their diligent work.

Mr. Speaker, I move the acceptance of this section of the report. The motion was seconded and carried.

Report of The Secretary

The excellent progress made by our Association in a number of areas during the past year is adequately demonstrated by reading the reports that you find in your House of Delegates envelope. Already, the impact of the expanded programs voted by the 1958 House of Delegates is beginning to be felt. We can look forward to much broader services in the coming year.

When we stop and reflect on the progress that has been made since 1949 by our Association, we cannot help but feel very proud. Not only has the number of services the Association is rendering to the public and profession been greatly expanded but the existing programs have been vastly improved. That the present program of the KSMA enjoys the active support of the membership as a whole is clearly shown by the fact that our paid membership at this writing is at an all time high.

It does, of course, as your Secretary, give me a great deal of pleasure to tell you of the accomplishments we are making in the fields of legislation, distribution of medical care in rural areas, services rendered the members in the field of medical education, medical literature as well as the fields of socio-medical economics and medical public services, during the past year.

But, gentlemen, I would remind you that while we have improved greatly, we have much further to go in preparing, for instance, our KSMA legislative "machinery" to meet the threats to medicine and pass constructive legislation both in Washington and Frankfort during the coming year. Although the Forand Bill (HR 4700) was temporarily sidetracked in July of this year, it is felt by the most informed opinion that it will be a blazing issue in January when the second session of the 86th Congress gets under way. Labor fully expects to pass some version of the bill.

In Frankfort, we must recognize that some form of indigent medical care will be voted by the Legislature at the 1960 session. We must not forget that KSMA, working with the allied professions on the health team, has an obligation to see to it that the best possible legislation in this field can be written, legislation that will prevent abuse, provide good medical care and guarantee the taxpayer his money's worth. Every member of KSMA has an interest in seeing that the proper legislation is passed.

No doubt there will be legislation presented in the field of prevention of contagious diseases, accident prevention and amendments to the Medical Practice Act. The Legislative Committee will be "on top" of these matters during the session, and will be communicating quickly with each of us. But gentlemen, remember, the Legislative Committee is no stronger than the SUPPORT THAT YOU AND I *GIVE IT*. The Legislative Committee cannot do the job alone. When the time comes, each member must do his share.

Other issues of great moment Kentucky physicians face include the matter of adequate medical care for the aged, providing machinery for the patient to properly prepay the cost of his medical care, and the resistance of third party encroachments.

Because of the foresight of the House of Delegates, we are better prepared to meet the demands of the future on all fronts. Yet, we have far to go in the direction of being fully prepared. So again, I would urge each member to consider it his personal obligation to his country, his profession and himself to accept and discharge his responsibility in these fields just as he would in the treating of the sick.

I want to report that the Board of Trustees of the American Medical Association has appointed our KSMA Executive Secretary, Joe Sanford, to serve a three-year term on its Communications Advisory Committee. The purpose of this nine-man group, made up of lay executives, is to advise the Director of the AMA's Communications.

I want to express my appreciation to the officers and Council of the Association for the good work they have done. Also, I am grateful for the cooperation of the Headquarters Office staff with my office.

Woodford B. Troutman, M.D.
Secretary

Recommendations, Reference Committee No. 1

The Report of the Secretary was studied with interest and unanimously approved.

The challenging remarks to the membership of the KSMA regarding support of the legislative committee is noted with gratitude.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Editor of The Journal

It has been less than a year since you honored Dr. George Pedigo and me, appointing us to the position of Associate Editor and Editor, respectively, of the Kentucky State Medical Journal. We moved into the position vacated by the retirement, and later the death, of Dr. Guy Aud, distinguished previous editor of the Journal. We did so with a sense of responsibility and deep gratitude for the trust and confidence reposed in us.

We found the Journal and its affairs in excellent condition. During the past 3 or 4 years there has been constant effort to improve the appearance and the quality of this publication. These improvements have met the hearty approval of the profession. Many complimentary remarks occasioned by these changes have encouraged us to make every effort to continue the program of improvement.

At a meeting of the Advisory Committee to the Editor on March 5, 1959, it was decided to make some changes in the cover of the Journal beginning with the June issue. This decision has been received with general favor.

It was determined at this meeting to devote one page to the problems of medical insurance which at the present time is under considerable discussion and change. Dr. Vinson Pierce has consented to carry this feature. Comments from the profession have been very favorable.

Policy with regard to the editorial page has been somewhat changed. Feeling the need of stronger and more detailed scientific editorials, we have recently attempted to find space for one good scientific article on these pages at least every 2 or 3 months and more frequently as the demand for other discussions may be less pressing.

We have requested that the term of appointment for the editor be one, or not more than 2 years, believing that this would be in the interest of a better Journal.

We will continue our endeavor to discharge in a creditable manner the commission which you have assigned us.

George W. Pedigo, M.D., Louisville
Associate Editor, KSMA
Sam A. Overstreet, M.D., Louisville
Editor, KSMA

Recommendations, Reference Committee No. 1

The Report of the Editor of the Journal of KSMA was studied and approved.

The Committee feels that the changes in the Journal are beneficial. The editors are to be commended for their interest and diligent work in this field.

Mr. Chairman, I move the adoption of this report.

The motion was seconded and carried.

Report of the Treasurer

The report of the Treasurer contained the recent audit of the Association's financial situation with statement of the income and expenses for the fiscal year ended June 30, 1959. (Editor's Note—Copies of the complete audit are on file in KSMA Headquarters Office for review by any member desiring to see it.)

The Treasurer's Report has been studied with gratification and approved in its entirety.

Mr. Chairman, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Delegates to The American Medical Association

In The Journal of the Kentucky State Medical Association for February, 1959, Doctor Robert Long gave a comprehensive report of the actions of the House of Delegates of the American Medical Association at the clinical session held in Minneapolis in December, 1958. A similar report concerning the Annual Meeting held in Atlantic City in June, 1959, was published in the August, 1959 issue of The Journal, by Doctor W. V. Pierce.

Since most of the delegates to the KSMA have had an opportunity to read these reports at the time they were published, it will not be necessary at this time to discuss the various items previously presented. Copies of the two reports are included in the folders of the delegates, along with this supplemental report; for consideration by the House of Delegates.

We feel that a few additional remarks should be made at this time to emphasize or supplement our previous statements.

During this year just past, the attendance at the sessions of the House of Delegates of the AMA by representatives of the Kentucky State Medical Association has been very gratifying. In addition to the two delegates, our association has been represented by the President or the President-elect; by the alternate delegates, by several members of the KSMA other than the above, and by the Executive Secretary of the Association. The Director of Field Services was also present at the June meeting in Atlantic City.

Your delegates wish to commend the House of Delegates of the KSMA for its wisdom in insisting that the alternate delegates attend the AMA meetings and for making it easier for them to do so by paying their expenses. We can assure you that the alternate delegates have been very active and diligent in attending reference committee meetings, and in expressing the viewpoint of our Association, at these meetings.

We regret that the recent illness of one of our alternate delegates, Doctor Foster Coleman, made it impossible for him to attend the last annual session; and we are greatly indebted to Doctor Karl Winter for consenting to serve in his place.

In this supplemental report, we would like to remind this House of Delegates of certain recommendations which the AMA has made to the constituent associations and to their members.

1. It is recommended that State and County Hospital Associations and Medical Societies assist and work together in the establishment of hospital Medico-legal and Education Committees to devise an effective in-hospital medical professional liability prevention program.
2. All medical society-sponsored prepayment health plans, such as the Blue Shield plans, are urged to expand their coverage and to increase the scope of their services; to try to prevent an increase in closed panel systems of practice; as well as to render a better service to the public.
3. State Medical Associations are requested to initiate and sponsor legislative activity to eliminate cancer quackery.
4. Greater interest in the American Medical Education Foundation is again suggested, with generous donations on the part of our physicians. It was pointed out that this is necessary in order to keep our medical schools solvent and progressive.
5. Continuing study on the problems of aging, and the furnishing of leadership in solving these problems, was repeatedly suggested.
6. All state medical associations are urged to consider the advisability of carrying out relative value studies along the lines of those which have been made in California and other states.

Your delegates again wish to acknowledge their indebtedness to the alternate delegates and others who attended the various reference committee meetings and reported back to us concerning the discussions at these meetings. In this way, we were better informed about the items on which we were to vote, than would have been otherwise possible.

We also wish to express our thanks to our Executive Secretary, Mr. Sanford, and to the rest of the Headquarters Staff for their invaluable assistance throughout the year.

Most especially, we desire to assure this House of Delegates that we appreciate the confidence and trust which you have shown in selecting us to represent you. Our objective has been, at all times, to carry out the wishes and mandates of this body, to the best of our ability.

W. Vinson Pierce, M.D., Covington
Robert C. Long, M.D., Louisville
KSMA Delegates to the AMA

Recommendations, Reference Committee No. 1

The Report of the Delegates to the AMA, with the exception of those sections referred to Reference Committees No. 3 and 5, was carefully studied and approved.

The Committee feels that KSMA has been represented with distinction, by our delegates and their alternates to the AMA.

Mr. Chairman, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Executive Secretary

The House of Delegates, the officers, Council and Committees of the Association direct and supervise the activities of the members of the Headquarters Staff.

The reports in your House of Delegates envelope describe the policies set by the appropriate and several authorities and reflect to a very considerable degree the breadth and volume of the activity of your Headquarters Office Staff during the past 12 months. This report will seek to be brief as it will attempt to cover some of the high lights not mentioned elsewhere in your envelope.

When the House of Delegates at its 1958 meeting voted to expand the services that the Association would offer its members and the public, it was necessary to secure additional manpower, and to reorganize the staff. Mr. Bobbie R. Grogan was assigned the title, Director of Field Services, and Mr. William E. Rudd of Madisonville was employed as the new Executive Assistant.

Mr. Grogan was assigned to work with the Legislative Committee, which absorbs a major share of his time; the Rural Kentucky Medical Scholarship Fund and the Physicians Placement Service, which go hand in hand, and to which he devotes a substantial amount of effort; to the Committee on Diabetes which sponsors the important annual public service known as the Diabetes Detection Drive, and to certain special assignments.

Mr. Rudd is serving as secretary to most of the "program committees" of the Association, which include such important assignments as the Committee on Public Information and Service, Committee on Medical Education and Economics, Committee on Postgraduate Medical Education and Committee on Medical Service. He handled the Athletic Injury Prevention Conference and is taking care of the promotion for the Rural Health Conference in November. In addition, he, too, accepts special assignments.

The Executive Secretary serves as secretary to the House of Delegates, Council, Executive Committee of the Council, Annual Meeting committees, the Board of Directors of the Kentucky Physicians Mutual, and is the managing editor of the Journal of KSMA. In addition, he works under the supervision of the KSMA President, Secretary, Treasurer, Speaker of the House, and Chairman of the Council in carrying out the directives of the Association. Under the supervision of the Council, he develops and promotes the Annual Conference of County Society Officers. Other major time-consuming responsibilities include supervising the staff, working with allied and related groups, promotion of the Congressional dinner in Washington, and communications.

Staff members have attended 87 KSMA Committee meetings. This involved promoting attendance, developing agenda, writing the digest and implementing the actions of the committees under their supervision. The same is true for the four meetings of the Council and the three meetings of the Executive Committee.

Regional and national meetings of vital interest to staff members and attended by them numbered 13. These included the AMA meetings, Public Relations Institute, Aging, Rural Health and others.

In the field of communications, the Headquarters Staff has had a busy year. Each month the Secretary's Letter and News Capsules are prepared under supervision of appropriate officials. The Staff has promoted all of the Councilor District Meetings, distributed numerous state-wide and district news releases, promoted attendance at this meeting through a broad program of information.

Another time-consuming responsibility, which will require more and more attention of the Headquarters Staff members, and which will undoubtedly bear dividends, is meeting and working with allied professional groups and other state-wide groups on matters of interest to medicine. During the past year staff members have attended 29 such meetings.

Each Monday morning, the Editor and Associate Editor of the Journal meet at 7:30 a.m. with the Managing Editor and his assistant. (We of the staff are most grateful for this interest on the part of our busy editors.) All non-scientific copy for the Journal is written, or gathered, by the staff. Other clerical and production responsibilities, which have greatly increased with our growing Journal, are handled by the staff.

The expanded programs of the Association were not foreseen when the present office space was arranged for. Now, the staff does not have adequate room in which to operate. This is not to be construed as being critical of any group or person. Medical Associations, in order to render effective service, must tailor their organization and activities in these days when the free practice of medicine is threatened from numerous directions to meet the needs of the hour. This is what KSMA endeavored to do, when it voted in 1958 to expand its program.

Mr. Grogan and Mr. Rudd join me in expressing our great appreciation for the opportunity of working with all KSMA Officers and Committees. We would like especially to express our gratitude for the direction and guidance of Robert W. Robertson, M.D., President; Garnett Sweeney, M.D., Chairman of the Council; Woodford B. Troutman, M.D., Secretary; Clyde C. Sparks, M.D., Speaker of the House; Irvin Abell, Jr., M.D., President-Elect; and Delmas Clardy, M.D., Treasurer.

To the women on our staff, I am deeply grateful for their loyal and splendid efforts in carrying out their duties during the past year. We are most fortunate in our personnel. To Mr. Grogan and Mr. Rudd, I want to express my deep appreciation for their loyalty to the Association, devotion to duty and efficient performance of responsibilities.

J. P. Sanford
Executive Secretary

Recommendations, Reference Committee No. 1

The Report of the Executive Secretary was carefully studied and approved.

The Committee wishes to express its appreciation for the consistently excellent work of Mr. Joe Sanford and his staff.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution A—Muhlenberg County Medical Society

WHEREAS, the Kentucky State Medical Association is a scientific and service organization with more than 2,000 members, serving both the public and profession;

WHEREAS, facilities at the present location having been outgrown are now inadequate and tend to reduce the efficiency of the service performed by the staff in the central office;

WHEREAS, it is appropriate that the Association's central office be housed in a building that is both adequate for future growth of the Association and at the same time be in keeping with the dignity and prestige of the Association.

AND WHEREAS, at least eight Southern States, including Tennessee, Alabama and Mississippi, have found it to their advantage to build their own quarters.

THEREFORE, BE IT RESOLVED that this House of Delegates authorize the Council of KSMA to name a three-man ad hoc committee to study the feasibility of the Kentucky State Medical Association

1. Purchasing a lot and building its own building
2. Purchasing a suitable building for occupancy
3. Make recommendations on how the project in either case might be financed.

Be it resolved that the Council of the Association make funds available for the payment of travel expenses of this committee to visit at least two nearby states whose medical associations are housed in relatively new quarters, for the purpose of studying them and profiting by their experiences.

Be it further resolved that this committee be instructed to report in writing to the House of Delegates at its 1960 meeting making such recommendations as it feels are in the best interest of the Association.

Recommendations, Reference Committee No. 1

Resolution A, presented by the Muhlenberg County Medical Society, was studied. This resolution points out the need for enlargement of the quarters for the KSMA offices, and recommends the creation of a committee to study these needs. This committee, if appointed, is to report to the 1960 meeting of the House of Delegates.

This resolution was discussed at considerable length and, although there was some opposition, the resolution was approved as submitted.

Mr. Chairman, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution E—On McDowell Stamp

"WHEREAS, Doctor Ephraim McDowell performed the first known successful abdominal operation on Jane Todd Crawford at Danville, Kentucky, on Christmas Day, 1809, and

"WHEREAS, the Kentucky State Medical Association has believed that it would be highly appropriate to honor this world-famous McDowell operation with the issuance of a commemorative stamp, and

"WHEREAS, it has respectfully petitioned the U. S. Postal Department to issue such a stamp,

"THEREFORE BE IT RESOLVED that this House of Delegates go on record as expressing its warm and deep appreciation to the U. S. Postmaster General,

Mr. Arthur Summerfield for his willingness to authorize the issuance of the commemorative stamp honoring Doctor McDowell this December, and be it further

"RESOLVED that this House of Delegates express its gratitude to the Postmaster General for making it possible to announce that the stamp would be issued at the time of the dedication of the restored Apothecary Shop as a part of the McDowell Shrine."

Robert W. Robertson, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The resolution on the McDowell Stamp, expressing appreciation to Postmaster General Summerfield, was approved.

Mr. Chairman, I move the adoption of Resolution "E."

Motion was seconded and carried.

Resolution F—On McDowell Stamp

"WHEREAS, the Apothecary Shop that was built in 1795 and was used by Doctor Ephraim McDowell in his practice of medicine at Danville, Kentucky, had fallen into a state of ill repair, and

"WHEREAS, the Kentucky Pharmaceutical Association has contributed funds and solicited additional funds from pharmaceutical manufacturers for the restoration of the Apothecary, and

"WHEREAS, after purchasing the land and restoring the Shop in a most substantial and appropriate manner, the KPA has deeded the Apothecary Shop to the Kentucky State Medical Association to be operated as a part of the McDowell Shrine, now

"THEREFORE BE IT RESOLVED that this House of Delegates go on record as expressing to the Kentucky Pharmaceutical Association its deep gratitude for this generous and most worthwhile effort, and be it further

"RESOLVED that this House of Delegates will assure both the members of the Pharmaceutical Association and the public that it will maintain the Apothecary in the best possible repair, and will look forward to operating it as a part of the McDowell Shrine for the benefit of the public."

Robert W. Roberston, M.D., President
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The resolution on the McDowell Stamp, expressing appreciation to the Kentucky Pharmaceutical Association, was approved by the Committee.

Mr. Chairman, I recommend the adoption of this resolution.

The motion was seconded and carried.

Resolution G—On McDowell Stamp

"WHEREAS, the Kentucky State Medical Association, when it decided to seek a commemorative stamp honoring Doctor Ephraim McDowell for performing the first successfully known abdominal operation, sought the help of Senator Thruston B. Morton and Senator John Sherman Cooper, and

"WHEREAS, the Senators and their staffs gave continued, enthusiastic, and effective support over a period of approximately 18 months, and

"WHEREAS, both Senators and their staffs were most cooperative and helpful to KSMA officials,

"THEREFORE BE IT RESOLVED that this House of Delegates go on record as expressing its unbounded appreciation to Senator Morton and to Senator Cooper for the contribution they have made in bringing recognition to Kentucky and for the honor that they have brought to this great Kentucky doctor, and be it further

"RESOLVED that this House of Delegates express its gratitude to the staff of the office of both Senators for their many courtesies and kindnesses, and for their untiring effort in seeking to have this stamp issued."

Robert W. Robertson, President
Kentucky State Medical Association

Recommendations, Reference Committee No. 1

The resolution on the McDowell Stamp, expressing appreciation to Senators Thruston B. Morton and John Sherman Cooper, was approved by the Committee.

Mr. Chairman, I recommend the adoption of the resolution G. The motion was seconded and carried.

Mr. Chairman, I move the adoption of the reports of Reference Committee No. 1, as a whole.

This motion was seconded and carried.

Reference Committee No. 1

W. Burford Davis, Louisville, Chairman
Loman C. Trover, Madisonville, Vice Chairman
Boyce E. Jones, London
James S. Williams, Nicholasville
John J. Rolf, Covington

REFERENCE COMMITTEE NO. 2

W. C. Hambley, M.D., Chairman

Reports on Medical Care, Medical Education Hospitals and Related Subjects

(Excerpt from the report of the president to the 1959 session of the House of Delegates which was referred to Reference Committee No. 2.)

While the future of the Keogh-Jenkins type legislation at this writing has not definitely been determined, it would appear that this Association should have some well-defined plan to take advantage of the benefits from such legislation, if enacted. We would, therefore, recommend that the House of Delegates authorize the KSMA Committee on Medical Education and Economics to study this bill carefully and be ready to make recommendations to the Council of KSMA on or before the 1960 County Society Officers Conference.

To date the need for a benevolent fund to take care of physicians and their family with acute or emergency financial problems in Kentucky has not been widespread. A number of state medical associations have such a fund; others are contemplating it. There does seem to be reasonable argument that the medical profession should be in a position to take care of its own who are in need. With this in mind, I recommend that the House of Delegates authorize the Speaker to appoint a special committee to study this matter, looking into the need, the manner in which distress fund might be financed, etc., and report back to the House at the 1960 meeting.

Recommendations, Reference Committee No. 2

That portion of the Report of the President having to do with the Keogh-Jenkins type legislation and to the need for a benevolent fund to care for distressed physicians and families was reviewed and approved, and we recommend their implementation.

We move the adoption of this portion of the report.

The motion was seconded and carried.

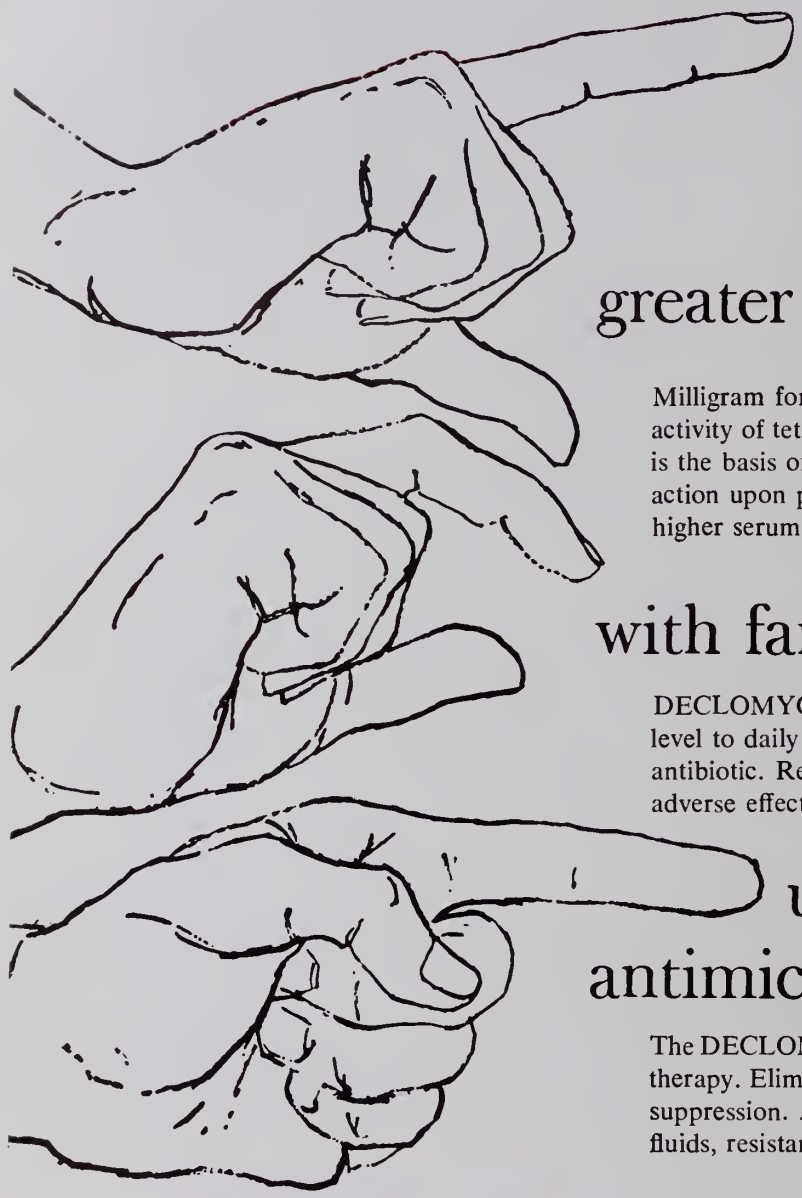
Report of The Medical Education and Economics Committee

A single formal committee meeting was held early in the calendar year for a review of the Indigent Medical Care bill preliminary to its being presented

(Continued on Page 1542)

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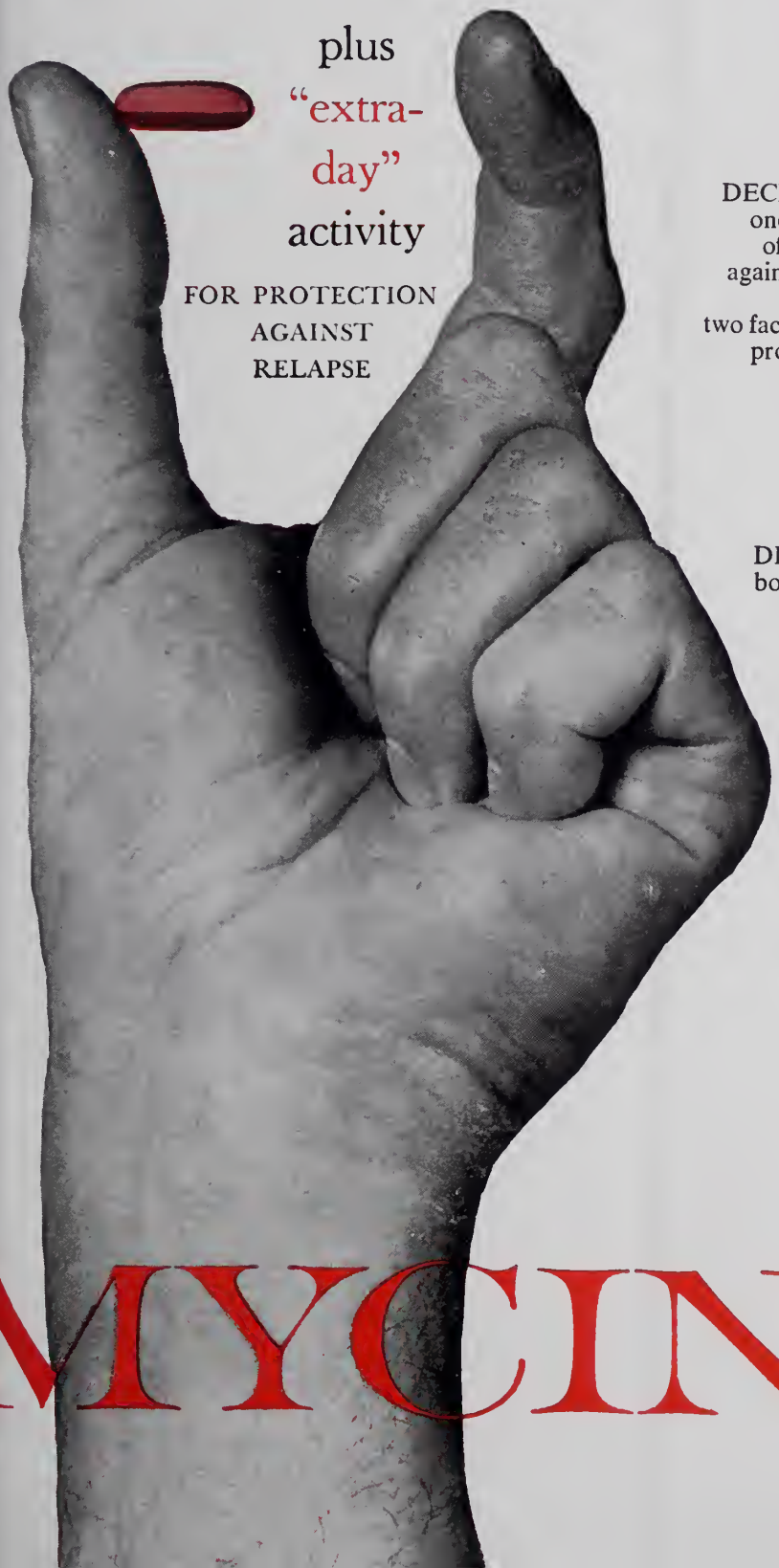
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(Continued from Page 1539)

to the Legislative Committee of the Kentucky State Medical Association for re-introduction at the next Kentucky General Assembly.

The Committee was represented at a meeting on May 10 with Lieutenant Governor Harry Waterfield and Judge Bert Combs who were Democratic candidates in the Primary Election held later in May. On July 28, conferences were held with Judge Combs and Mr. Wilson Wyatt, Democratic candidates for Governor and Lieutenant Governor, and Mr. John M. Robsion, Republican candidate for Governor in Kentucky. In each instance the Indigent Medical Care Program was discussed. During the year we were represented at two meetings of the Council on Allied Medical Services of Kentucky for the same purpose.

Currently it is contemplated that the Council on Allied Service will sponsor at the next General Assembly in Kentucky a plan which will establish some form of Indigent Medical Care to the bonafide indigents—excluding the medically indigent—comprising those people who are on public and general assistance rolls, and for the care of acute illnesses and injuries only. There is to be at least one exception, namely, an arrangement whereby a physician practicing in any of the ten so-called disaster counties (those with a very high patient-physician ratio) currently to be compensated for out-patient care.

The Medical Economics Committee feels that this Association should seriously consider adopting a relative fee schedule. There are a number of states which now have this arrangement. One of its prime advantages is its assistance to medical care insurance carriers in arriving at actuarial data concerning premiums, etc. Although it does not fix the fees, it is a deterrent to the "chiseler" who brings disrepute to the profession.

We had hoped to be able to present some pertinent data on the Simpson-Keogh Bill but as of August 15, the Congress has not taken definite action on it. It is entirely possible however, that a supplementary report on this matter will be available by the September, 1959 meeting date.

The Associate Committee reports are as follows:

I. Associate Committee on Insurance—Dr. R. E. Reichert, Covington, Chrm. "In response to your letter of July 2nd, no meetings of the Insurance Committee were held during the year and no report is therefore to be given.

"No problems were presented to this committee and thus the reason for the committee not meeting."

II. Associate Advisory Committee to University of Louisville School of Medicine—Dr. D. P. Hall, Louisville, Chairman.

"The Advisory Committee on Medical Education for the University of Louisville School of Medicine does not have a report to make as there has been nothing of significance to come before it."

III. Associate Committee on Federal Medical Services—Dr. O. L. Higdon, Paducah, Chairman.

"The KSMA Committee on Federal Medical Services held its first meeting on November 20, 1958, for the discussing of the Veterans Administration Fee Schedule for Medical Services. From this meeting and with considerable correspondence, a revised fee schedule was accepted by the V.A., and these changes were also accepted by the KSMA Council.

"A letter dated April 10th was mailed to all county society secretaries, calling attention to a proposed meeting of this committee in June to study and discuss the fee schedule for the Department of Defense relative to providing medical care under certain conditions to dependents of personnel in the Armed Forces. It was requested in this letter that any suggestions or comments in regard to this schedule be forwarded to the KSMA Headquarters Office. This information was also publicized in the KSMA Journal. No communications were received from any physician or county secretary; so, the meeting was cancelled with a recommendation that the present fee schedule be renewed for another year. This recommendation was accepted by the Executive Committee of the KSMA Council."

IV. Associate Committee for Contribution to the American Medical Education Foundation—Dr. C. C. Waldrop, Williamstown, Chairman.

Doctor Waldrop reports that no meetings were held during the year.

We wish to express our appreciation to the personnel in the Headquarters Office for their very excellent cooperation with us during the past year.

Medical Education and Economics Committee

J. A. Bishop, M.D., Jeffersontown
D. P. Hall, M.D., Louisville
O. L. Higdon, M.D., Paducah
C. C. Waldrop, M.D., Williamstown
G. L. Simpson, M.D., Greenville, Chrm.

Recommendations, Reference Committee No. 2

This report also includes the reports of the Associate Committee on Insurance, the Associate Advisory Committee to University of Louisville School of Medicine, the Associate Committee on Federal Medical Services, and the Associate Committee for Contribution to the American Medical Education Foundation. The Associate Committee reports are accepted without discussion by this Committee.

That portion of the report pertaining to legislation for indigent care is accepted in principle. This Committee recommends that no provision be made for payment for physicians' services to the indigent at this time. This Committee recommends that the Council inform the membership of the nature of the relative fee schedule and poll the membership for information relative to fees, and to retain this information for reference only. We move the adoption of this portion of the report.

The motion was seconded and carried.

Report of The Medicare Review Committee

The Medicare Review Committee consisting of three members has performed its function throughout the year 1958 and 1959. Some two hundred to two hundred and fifty cases have been referred to this committee by its fiscal agent, the Kentucky Physicians Mutual, Inc.

The chairman of this committee in the spring of this year met with officials of the Dependent's Medicare Program from Washington and it was felt that as a result of this meeting a better understanding between the fiscal agent, the Medicare Review Committee and Washington was established.

The Medicare Review Committee would like to recommend that this committee be composed of more members serving a term of three years and that it be composed of representatives of the more varied specialties.

Medicare Review Committee

J. A. Bishop, M.D., Jeffersontown
R. C. Long, M.D., Louisville
R. H. Moore, Jr., M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

Report of this Committee was studied and accepted. We move the adoption of this portion of the report. The motion was seconded and carried.

Report of The Advisory Committee to The University of Kentucky

Your committee held a regularly scheduled meeting at the Campbell House in Lexington on the evening preceding the Officers Conference. A grand attendance, and a good meeting followed.

Dean Willard and his associates gave a vivid description of the progress being made at the Center and the plans for future developments, especially for the faculty of the Medical School. At the time this report is filed, plans are in progress for a meeting of Dean Kinsman of the University of Louisville Medical School, and Dean Willard of the University of Kentucky Medical School, the chairmen of the two advisory Committees to each school and Mr. Gaines Davis, legal advisor to KSMA, to meet for further discussion of medical fees to be charged for the services of members of the staffs of each school. A supplementary report of that meeting shall be on record.

Advisory Committee to the University of Kentucky

H. C. Denham, M.D., Maysville, V-Chrm.
C. B. Wathen, M.D., Owensboro
D. M. Clardy, M.D., Hopkinsville
S. A. Overstreet, M.D., Louisville
J. T. Funk, M.D., Bowling Green
B. B. Baughman, M.D., Frankfort
C. W. Kumpe, M.D., Covington
C. C. Johnston, M.D., Lexington
J. M. Bush, M.D., Mt. Sterling
W. V. Lyon, M.D., Ashland
L. Caudill, M.D., Morehead
P. B. Hall, M.D., Paintsville
C. B. Stacy, M.D., Pineville
C. D. Cawood, M.D., Middlesboro
H. McPheeters, M.D., Louisville
R. E. Teague, M.D., Louisville
C. C. Howard, M.D., Glasgow
O. L. Higdon, M.D., Paducah, Chairman

Recommendations, Reference Committee No. 2

The report of this Committee was reviewed, and considerable discussion was provoked. This Committee recommends this report be accepted for information only. In the discussion that ensued, the Committee was in unanimous agreement that the Kentucky State Medical Association should not fix the fees for any group of physicians. All were concerned about the inconsistencies arising from the fact that on the one hand the so-called need for the use of private patients for teaching purposes is given as justification for consideration of fixing the fees of those physicians concerned, while on the other hand Kentucky has been pointed up as an area with a very high indigent population, and efforts are being made to obtain funds for the indigent care. The Committee feels that there is available more than sufficient indigent patients for teaching purposes.

We move adoption of this portion of the report.

Motion was seconded and carried.

Report of the Committee on Scientific Assembly and Arrangements

This Committee has held three meetings this year and sponsored another meeting with the 13 presidents of the Specialty groups within KSMA that cooperate in presenting the Scientific Program. Our Committee feels that the 1959 program will be most worthwhile and trust you will find it profitable.

A recommendation adopted by this Committee that came out of the meeting with the Specialty Group presidents was that there be two specialty groups half-day sessions instead of one, with half of the organizations presenting the Tuesday afternoon program and the other half the Thursday morning program. This will allow a greater interchange of information and the men in General Practice to attend other specialty group meetings in addition to their own.

Other innovations are that in addition to paying the maintenance and transportation expenses of guest speakers (not to exceed $150.00) the Association will give each speaker an honorarium of $50.00, (this recommendation was made to and accepted by the Council). For the first time, KSMA will provide each specialty group with visual aid equipment—responsibility of operation of the equipment will be that of the specialty group.

For the past few years, we have had 13 specialty groups meeting. This year, we will have only 12, six on Tuesday afternoon and six Thursday morning. The Radiology group is not having a specialty group meeting because their national organization is having a meeting in Cincinnati, Ohio, at the same time. The radiologists are, however, providing the committee with an outstanding, nationally known personality, who will come down from Cincinnati to take part in our program.

Our committee is deeply grateful to Beverly Towery, M.D., who had charge of actually putting the program together. Doctor Towery, who heads the Department of Medicine at the University of Louisville, worked long and hard in arranging our diversified and excellent program this year.

Two of the associate committees of this Committee —Scientific Exhibits and Technical Exhibits—have long since filled the space allotted to them. To the Chairman of the former, Everett L. Pirkey, M.D., head of the Department of Radiology at the School of Medicine, we want to say thank you for another excellent piece of work.

We want to express our gratitude to Kenneth L. Barnes, M.D., Princeton, who chairs the committee on Technical Exhibits. This committee sells space from which income is derived to finance this meeting. Doctor Barnes urges that the Specialty Groups respect and keep faith with both Scientific and Technical Exhibitors during the two sessions—and see that their members visit the Exhibits during the 30 minute intermissions.

Our Committee as a whole urges you to visit both exhibits at every opportunity. There is a wealth of information, all practical and profitable, in these exhibits that will enable you to render to your patients a more efficient service.

Because of the importance to all of us, we are using the full report of the Associate Committee on Postgraduate Medical Education, which is an associate committee of this group:

The Committee on Postgraduate Medical Education during the past year has been re-organized as to membership. The members of the present Committee represent most of the medical organizations in the state that have an active interest in postgraduate medicine. The Committee has been organized such that the appointments to the Committee will have three-year terms. This permits a continuity which was not available when members were appointed on a yearly basis. One of the main objectives of the Committee was to promote cooperation among the different groups in the field of postgraduate medicine and to prevent conflict of scheduling. This is working out very well as all of the groups, including the two medical schools and the Academy of General Practice, are now using the state Committee as a clearing house before setting dates and subjects of postgraduate medicine.

The Committee has been called on to provide speakers for numerous local and sectional meetings throughout the state. The speakers have been of high caliber and the meetings have been well received.

It is the objective of the state Postgraduate Committee to promote postgraduate activities throughout

the state and to increase the number of postgraduate activities available to the members of the State Medical Association.

In order to do this an office of postgraduate medical education is being set up in Louisville. This office will serve both the University of Louisville and the University of Kentucky. The University of Louisville will provide office space. An Executive Director is to be obtained as well as an office force. It will be the principal objective of this office to develop and put on postgraduate courses by the University of Louisville and the University of Kentucky. It is anticipated that this office will be in operation within this coming year.

Committee on Scientific Assembly and Arrangements
Irvin Abell, Jr., M.D., Louisville
Beverly T. Towery, M.D., Louisville
Frank L. Duncan, M.D., Monticello
George F. Brockman, M.D., Greenville
Kenneth L. Barnes, M.D., Princeton
Everett L. Pirkey, M.D., Louisville
R. W. Robertson, M.D., Paducah, Chairman

Recommendations, Reference Committee No. 2

This report was reviewed, discussed, and accepted as read.

We move the adoption of this section of the report. The motion was seconded and carried.

Report of The Committee on Allied Professions

The Kentucky State Medical Association Committee on Allied Professions submits the following report:

ADVISORY COMMITTEE ON BLUE CROSS, Sam A. Overstreet, M.D., Louisville, Chairman.

The Associate Advisory Committee meets once each year and discusses Blue Cross operations. These opinions are transmitted to the office of Blue Cross-Blue Shield. Several items of importance will be discussed at our September 21 meeting.

DENTAL COMMITTEE, James S. Rich, M.D., Lexington, Chairman.

The KSMA Dental Committee has held no meetings during the year as there were no matters brought to its attention.

COMMITTEE ON HOSPITALS, Samuel H. Flowers, M.D., Middlesboro, Chairman.

There have been no meetings during the year inasmuch as there have been no problems directly referred to the committee this year.

COMMITTEE ON NURSE TRAINING, Henry B. Asman, M.D., Louisville, Chairman.

The Nurse Training Committee held one meeting on May 21, 1959 in Louisville.

The meeting had primarily a twofold purpose; one, to study the shortage of nurses in compliance with the 1957-58 House of Delegates' request, and second, to study the request from the Association of Registered Nurses that the KSMA issue a statement in regard to the nursing shortage along with a gesture of cooperation and assistance to the nursing profession.

In response to these requests the Committee issued a statement, which was felt would serve both purposes. The statement which was approved by the Executive Committee of the KSMA Council is as follows:

"The Kentucky State Medical Association, in recognizing the needs for an increasing number of nurses of all types and categories, hereby offers to the nursing profession its expression of willingness to cooperate within the limits and scope of our ability.

"It is to be understood that this expression is offered in a sincere spirit of cooperation by the Association and is not meant to be construed as critical, fault-finding, or dictatorial. The Kentucky State Medical Association is fully aware that the primary responsibility in the training and supplying of nurses is a function of the nursing profession.

"Recognizing that there are many fields of nursing for which candidates must be trained, in addition to bedside nursing, we believe, however, that the greatest need at this time is for the bedside nurse. With this in mind, we respectfully suggest that those in charge of nursing school curricula re-evaluate their programs, placing greater emphasis on the clinical phase of training, i.e. the actual care of the sick patient under close supervision. We may cite, in this regard, the trend over the past ten or fifteen years in medical education to reduce the didactic teaching and emphasize the clinical instruction—to the extent that the student has contact with patients from his first year of schooling, and his final two years are devoted almost entirely to such experience. The basic sciences, theory, and principles of medicine are essential to good nursing as well as to good medicine, but the ultimate goal is the intelligent application of this knowledge. This cannot be taught in a classroom but comes as a result of experience in the sick room.

"Specialization in nursing, such as public health, industrial, rehabilitation, psychiatry, etc., should come through postgraduate study, just as the physician takes a residency, a fellowship, or postgraduate courses.

"We believe that the statement that 'the use of student nurses for floor duty in the hospital is exploitation of the student' is not a valid one. The clinical experience thus gained, developing a sense of responsibility and confidence that is so important, should be looked upon as a most essential part of her training.

"In order to implement the program of cooperation, the members of KSMA are urged to visit those who control nurses' training programs in their local hospitals and express a desire to be of help in any way possible. Those who are members of nursing committees in the hospitals are in a particularly advantageous position to render valuable service to both the medical and nursing professions as well as to the hospital. It would seem, however, that in many instances the initiative must come from the physician.

"This committee also recommends that a physician should be appointed as an advisor or consultant to the Nurses Training Division of the Nurse Examining Board.

"In addition, as a possible aid in the alleviation of the shortage of nurses, we suggest as another avenue of approach, the training of licensed practical nurses or other qualified individuals, by means of a suitable course of instruction for service as technicians in the fields of obstetrics, surgery, etc. This is being done at the present time in one of the larger private hospitals in Louisville, and the program has been eminently successful.

"It is further suggested that members of KSMA should cooperate more fully with nurse recruiting programs through the county medical societies, hospital staffs, auxiliaries, civic clubs, and various other local contact."

Although this report is not all conclusive it is felt to be a step in the direction toward better relations with the nursing profession.

COMMITTEE ON PHARMACY, Michael R. Cronen, M.D., Louisville, Chairman.

The Pharmacy Committee has held no meetings during the year.

KSMA ADVISORY COMMITTEE ON PUBLIC HEALTH, Delmas M. Clardy, M.D., Hopkinsville, Chairman.

The Advisory Committee on Public Health of the Kentucky State Medical Association met March 19, 1959. The plans for Immunization Week, May 4—May 9, were reviewed and approved. The usual methods of publicity will be carried out with emphasis upon more effort at the "grass roots" and personal contact of the County Medical Society committees or officers with the managers of the publicity media.

Compulsory immunization for diphtheria, pertussis and tetanus, and polio along with smallpox was recommended by the Committee and it was urged that the Kentucky State Medical Association support such legislation.

The use of BCG vaccine is of controversial nature. It was decided that the practices of the United States Public Health Service and the Kentucky State Department of Health should be followed.

It was emphasized that the value of influenza vaccine has been established. Its use for the aged and those patients with chronic heart and lung disease is important. This announcement was made by the Surgeon General of the Public Health Service recently.

There are many preventable deaths in Kentucky each year from causes other than from communicable diseases with which the physicians of Kentucky should concern themselves. The leading of these are deaths from automobile accidents; approximately 800 in Kentucky in 1958. The Committee recommends the following prescriptions for programs in attempt to improve this terrible loss of life and expensive, disabling injuries:

1. Improve law enforcement, both by the police and by the courts.
2. Tighten up issuance of licenses and registrations.
3. Increase educational efforts in accident prevention.
4. Continue efforts to build safety into cars. Manufacturers should try to sell such features as rear window wipers, defrosters and seat belts.
5. Stop exulting over statistical drops in auto deaths. These are no indication of traffic safety, representing only .4% of auto accidents.
6. Research in the problem of emotions and accidents. Studies indicate that the aggressive, unstable, nonconforming and anti-social person is likely to cause highway accidents.

It has been said by eminent authorities that no woman should die of cancer of the cervix. The Committee thinks that more use should be made of the exfoliative cytology technique in attempt to diagnose cancer of the cervix while it is curable. Services of qualified laboratories are now available at reasonable costs to both the physician and patient. The technique of slide preparation is simple. Valuable information is obtainable from both the American Cancer Society and the Kentucky Cancer Society for the asking.

After 12 years experience and data on fluoridation of public water supplies, it is shown that fluoridation is about 60% effective in prevention of dental caries. Only about 25% of the public water supplies in Kentucky are fluoridated. The Committee urges a 100% fluoridation program for Kentucky.

All of these recommendations are in line with the objectives of the United States Public Health Service and the Committe thinks they should be released to the press at the earliest possible date.

KSMA ADVISORY COMMITTEE ON SCHOOL HEALTH, Carroll L. Witten, M.D., Louisville, Chairman.

The KSMA Advisory Committee on School Health held two meetings during the year; January 8, 1959, and May 7, 1959.

At the first meeting on January 8, in compliance with the 1955 House of Delegates request, the Kentucky Advisory School Health Council was formed with a goal of bettering the health care of the school-age child.

This Council has been active in the formulation and revision of the school health code and the health record cards.

Another important function of this committee was the presentation of an Athletic Injury Prevention Conference in Lexington on August 12. This was the first time a conference on this order has been scheduled in Kentucky and attendance was very good.

Other activities of the committee included the mailing of some 1600 letters to County school superintendents, independent school superitendents, Lions Clubs, Health departments and PTA members in regard to the telabinocular visual screening process.

This committee also recommended to the Public Health Committee that in addition to the smallpox vaccination, all children be required to receive innoculation against diphtheria, pertussis, tetanus and polio prior to entrance to school.

Committee on Allied Professions
Sam A. Overstreet, M.D., Louisville
James S. Rich, M.D., Lexington
Samuel H. Flowers, M.D., Middlesboro
Henry B. Asman, M.D., Louisville
Michael R. Cronen, M.D., Louisville
Delmas M. Clardy, M.D., Hopkinsville
Carroll L. Witten, M.D., Louisville
Charles M. Edelen, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 2

This report consisted of reports of the Advisory Committee on Blue Cross, Dental Committee, Committee on Hospitals, Committee on Nurse Training, Committee on Pharmacy, KSMA Advisory Committee on Public Health, and KSMA Advisory Committee on School Health.

This report was approved, except for that of the KSMA Advisory Committee on Public Health, which was referred to Reference Committee No. 3.

The Committee felt that some attention should be given to the training of clerical help, such as ward clerks and stenographers, to relieve the nurses of these chores and provide them with more time for bedside nursing. We move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Professional Relations Committee

This Committee is composed of the immediate five past presidents of the Kentucky State Medical Association, and its function is to look after grievances that the public or other physicians might have against members of this Association. The work of the Committee this year has been light. It handled only three complaints. Much of the work that formerly occupied its attention is being handled by the local grievance committees of the various medical societies of the State.

Three complaints were received by the Committee: One concerned the only doctor in a small town, who refused to see four children after office hours. The lady that made the complaint was under the impression that a doctor had to see anyone, at any time, regardless of whether it was an emergency or not and at the conveniece of the person that wished to see him. It was pointed out to her that a medical man was like anyone else—that he had to sleep and that one of the problems we had was to keep one medical man happy as he was the only physician in the town; that if it were an emergency, we felt sure he would see the patient; but if it were not an emergency, we did not think it was unreasonable of him to expect to see the patients during the office hours. This letter was sent to the doctor. The doctor and the patient were advised to get together.

One complaint was investigated thoroughly concerning the United Mine Workers and two physicians who operated upon one of the U.M.W. patients. It was thought important enough to call a meeting of the Grievance Committee to discuss the case, but it was decided that the case belonged to the Committee on Third Party Medicine, and all of the reports were turned over to its Chairman.

The third case was a complaint about fees. Several specialists in this particular line of work were queried about their standard fee for this type of care. The fee was found to be reasonable and not above the standard fee. The person making the complaint was notified. The person also complained about the hospital fee; and while it seems steep, he was informed that organized medicine had nothing to do with the hospital fees; that the physicians do not have any control over hospital charges; and that he should take his complaint to the hospital association.

These three complaints are similar to those which the Committee has dealt with in the past five years that I have served on the Committee. All are roughly in three categories: (1) Patients not being able to get the doctor when they want him or that he neglected them; (2) Third party intervention in the care of the patient and the doctor; and (3) A question of whether the fees were fair and reasonable.

We must strive to give people the best care possible at a fee that they can afford to pay. We need an education campaign: (1) to educate the doctor as to the desirability and necessity of taking care of people when they are called, and (2) the patient be reasonable in his demands upon the physician; to realize that he is not the only patient the doctor has and the doctor is only human and can only do so much.

The high cost of medicine is blamed upon the physicians, regardless of the fact that the physician's fee, itself, may be only a small part of the cost. The physician is held responsible for the hospital charges and the pharmaceutical charges, neither of which he has any control over. We must educate the people to differentiate between fees that the doctor charges from the cost of his hospital care and drug fees.

Professional Relations Committee

J. Duffy Hancock, M.D., Louisville
Clyde C. Sparks, M.D., Ashland
Richard R. Slucher, M.D., Louisville
Edward B. Mersch, M.D., Covington
G. Y. Graves, M.D., Bowling Green, Chairman

Recommendations, Reference Committee No. 2

Report was reviewed, and it was pointed out that grievances fall into three general categories, those having to do with (1) patient dissatisfaction, (2) third party intervention, and (3) question of fees.

It is recommended that that portion of the report concerning the need for an education campaign be referred to Committee on Public Information and Service for implementation.

We move the adoption of this portion of the report. The motion was seconded and carried.

We move the adoption of the report as a whole. The motion was seconded and carried.

Reference Committee No. 2

W. C. Hambley, M.D., Pikeville, Chairman
Robert S. Tillett, M.D., Louisville, Vice-Chairman
Gladys L. Rouse, M.D., Florence
Alex Spencer, M.D., West Liberty
C. R. Lewis, M.D., Georgetown

REFERENCE COMMITTEE NO. 3

Russell L. Hall, M.D., Chairman
Reports on Legislation and Public Relations

(Excerpts from the report of the Council to the 1959 Session of the House of Delegates which were referred to Reference Committee No. 3)

(Second Meeting)

Comments were heard from the Commissioner of Health who also read a recommendation by the AMA in regard to poliomyelitis inoculation. This program was discussed and the Council approved the recommendations of the AMA House of Delegates and instructed the Headquarters Office to mail the recommendation and steps to be taken to all county medical societies.

(Third Meeting)

Following a report by Delmas M. Clardy, M.D., Hopkinsville, chairman of the KSMA Advisory Committee on Public Health, the Council voted to:

1. Recommend compulsory vaccination for diphtheria, pertussis, tetanus, and polio for all children prior to entrance in grade school.

(Fourth Meeting)

The Council then decided to support legislation that would provide funds for compulsory vaccination and referred a request for a study on privileged communications to a special committee.

Recommendations, Reference Committee No. 3

This Committee was to consider the section concerning *compulsory vaccination* only. Action of this Committee on this part of the report is stated under Resolution "J", which Resolution is on the same subject.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution B—Jefferson County Medical Society

TO: House of Delegates, Kentucky State Medical Association
FROM: The Delegates of the Jefferson County Medical Society
SUBJECT: Kentucky Constitutional Convention

WHEREAS, it is important to the medical profession that people of high caliber be appointed or elected to public office, and

WHEREAS, the Constitution of Kentucky imposes unrealistic limitations on the salaries of the public officers and employees, and

WHEREAS, under the present restricted salary possibilities many of our qualified and dedicated public employees may well be attracted to positions in other states or private employment, and

WHEREAS, the Amendment to the Constitution voted in 1949, concerning compensation for public officers and employees in Kentucky does not adequately serve for its intended purpose and other sections of the Constitution are known to be inadequate for modern day government;

THEREFORE, BE IT RESOLVED, that the medical profession of Kentucky hereby declares its dissatisfaction with the present state constitution and its mode of revision by amendment and does hereby recommend that the public officials responsible therefor call a Constitutional Convention at the earliest possible date.

BE IT FURTHER RESOLVED, that this Resolution be transmitted to all candidates for Governors and Candidates for the Legislature of Kentucky before the November 3, 1959, election so that the next Governor may know that the medical profession

would respectfully request the next General Assembly to take the necessary steps for calling a Constitutional Convention.

Recommendations, Reference Committee No. 3

This Resolution is on the subject of calling the Kentucky Constitutional Convention. The Reference Committee agrees with the intent of the Resolution and urges further study and solicitation of support from all interested groups and recommends this Resolution be referred to the Committee on Legislation for its continued study.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution J—Harlan County Medical Society

WHEREAS, There are still too many young children in the State of Kentucky who are not immunized against diphtheria, pertussis, tetanus, and polio, and

WHEREAS, Cases of tetanus and diphtheria continue to occur sporadically, minor epidemics of pertussis and polio are occurring even in the enlightened and advanced year of 1959, and

WHEREAS, There is no effective method of preventing these diseases in the community other than by immunization, and

WHEREAS, There are effective and safe vaccines for the prevention of these diseases, and

WHEREAS, Vaccination for the prevention of smallpox is already required before one year of age, and

WHEREAS, Early immunization has become an accepted procedure by medical authorities and the medical profession and by most of the general population, Therefore, be it

RESOLVED, That the Kentucky State Medical Association go on record as approving immunization against diphtheria, pertussis, tetanus, and polio before the end of the first year of age, and Further, be it

RESOLVED, That the Kentucky State Medical Association sponsor or encourage legislation to require immunization against diphtheria, pertussis, tetanus, and polio before the end of the first year of age.

Sandford Logan Weiler, M.D.
Vice President

Recommendations, Reference Committee No. 3

This Resolution is on the subject to sponsor legislation to require immunization against diphtheria, pertussis, tetanus and polio before the end of the first year of age. This resolution covers your Committee's recommendations also concerning that part of Report No. 4 which requires compulsory vaccination before school age. The Reference Committee recommends the adoption of Resolution "J" in toto.

Mr. Speaker, I move the adoption of this section of the report in recommendation as given.

After discussion, a motion was duly made and seconded that this section of the report be referred back to the Advisory Committee on School Health to report at the 1960 Session of the House of Delegates.

Resolution K—John W. Meredith, M.D., Scottsville

1. WHEREAS, In 1955 the Defendants, The Iowa State Medical Society and the Iowa Pathologists Association Et Al, obtained a Decree in the Ninth Judicial District of Iowa, in Case Number 63095 Equity, rendered by Judge C. Edwin Moore on the 28th day of November 1955 at Des Moines, Iowa, in which the Plaintiff Hospitals named in the action were found guilty of the corporate practice of Radiology and Pathology and were ordered to cease such practices.

And, Whereas, a specific law to this effect in the succeeding legislative session was further placed in the Iowa Statutes and is now in full force and effect since April 11, 1957, as in Chapter 92 H.F 21 of the Laws of the State of Iowa:

1-A. Specifically, the Decree of Judge Moore stated:

2.—"The Court declares that Plaintiffs, be they Corporations or Individuals serving as trustees for County Hospitals under the provisions of Chapter 347 of the Code—, in conducting and operating Hospital Pathology Laboratories as found in the Court's Find of Facts, are selling to the public, as Pathology Laboratory Services, medical services performed and furnished in the diagnosis and treatment of human injury and disease including the services of the Pathologist himself, if there be one, and as such are engaged in the unauthorized, unlicensed, and illegal practice of medicine."

3.—Paragraph Three of Judge Moore's Decree held the same to be ordered in regard to X-Ray Services:

"The Court does hereby retain jurisdiction of this cause for the granting of relief supplemental to the declarations herein made wherever necessary or proper."

2. WHEREAS, the Laws of the State of Kentucky already prohibit the corporate practice of Medicine, Dentistry, and Law, and prohibit the illegal practice of Medicine:

3. WHEREAS, many Hospitals in Kentucky are now and have been for several years engaged in the same type of corporate practice of Radiology and Pathology and Clinical Pathology as was held illegal under the Iowa decision:

4. WHEREAS, in many cases the Code of Conduct of the Law of the State of Kentucky, which prohibits hospitals making a profit on the services of professional services of physicians, mainly pathologists, laboratory directors, and radiologists, is being violated:

5. BE IT HEREBY RESOLVED AND ORDERED that the Kentucky State Medical Society conduct an investigation to determine which hospitals are violating either the Code of Conduct of Chapter 150 of the Acts of the General Assembly of Kentucky, or the Corporate Practice of Medicine, or Illegal Practice of Medicine. If such is found to be the case the House of Delegates of the Kentucky State Medical Society instructs the Officers and the Council of the said Society to proceed without delay in filing suits in the Courts of Kentucky against all offenders of said Statutes.

6. BE IT RESOLVED that a report of these investigations and court actions, if any are necessary, be made to the members of the Society on request, and at the interim meetings of the House of Delegates and at the next annual meeting of the Kentucky State Medical Association, and as instructed by the House of Delegates at subsequent meetings.

7. BE IT RESOLVED by the House of Delegates of the Kentucky State Medical Association that the Legislative Committee of the Kentucky State Medical Association and the Attorneys for the KSMA attempt to obtain passage by the next session of the General Assembly of Kentucky, of a bill providing for specific clarification of the issues in line with the Law enacted by the Iowa Legislature on the subject of the corporate practice of Radiology and Pathology and Clinical Pathology, and also to take into consideration the provisions already in effect in the State of Kentucky in the Code of Conduct for Physicians, as authorized and adopted by the State Board of Health of Kentucky; and also shall conform with the recommendations of the American College of Radiology in the Guide for Radiologist—Hospital Relations.

8. A transcript of the adopted Law of the State of Iowa passed by the Fifty-Seventh General Assembly, Chapter 92, H. F. 21, titled "An Act Relating to Pathology and Radiology Services in Hospitals," is hereby presented.

Presented to the 1959 Meeting of the Kentucky State Medical Association House of Delegates by John W. Meredith, M.D., Member of the KSMA.

John W. Meredith, M.D.

Recommendations, Reference Committee No. 3

This Resolution concerns court decisions against hospitals in Iowa for certain practices regarding pathologists and radiologists, and requesting this Association to attempt to obtain passage in the General Assembly of bills clarifying the issues in line with the law enacted by the Iowa Legislature on the subject of corporate practice of radiology and pathology. There appeared before the Committee Doctor Robert Sheppard, Radiologist, Lexington, Kentucky, who requested that the State Radiological and Pathological Societies be given a chance to clarify or correct any existing irregularities in the relationship between hospitals and these particular specialties. It was the unanimous opinion of the members of this Committee that while we are sympathetic with, and approve of the context of this Resolution, we would recommend that this problem be referred to the State Radiological and Pathological Societies specifically requesting their study and recommendations concerning the proper action to be taken.

It is further recommended that these Societies be fully aware that there exists in the State of Kentucky irregularities in the ethical relationship between hospitals and these particular specialties, and that steps be taken to correct such practices in accordance with the standards set down by their specific Colleges.

The recommendations of these Societies are to be referred to the Council of the KSMA at the earliest possible date.

Mr. Speaker, I move the adoption of this section of the report with the above recommendation. The motion was seconded and carried.

A motion was then made, seconded and carried, that the last sentence in the first paragraph be amended to read: "It was the unanimous opinion of the members of this Committee that while we are sympathetic with and approve of the context of this resolution, we would recommend that this problem be referred to the State Radiological Society, Pathological Society, and Anesthesiology Society specifically requesting their study and recommendations concerning the proper action to be taken."

Mr. Speaker, I move the adoption of this Report as a whole. The motion was seconded and carried.

Reference Committee No. 3

Russell L. Hall, M.D., Wheelwright, Chairman
Henry F. Chambers, Jr., M.D., Campbellsville, Vice Chairman
Robert L. McClendon, M.D., Louisville
Robert B. Warfield, M.D., Lexington
Hubert C. Jones, M.D., Berea

REFERENCE COMMITTEE NO. 4

Robert S. Dyer, M.D., Chairman

Reports on Miscellaneous Business

Report of The Committee to Study The Constitution and Bylaws

The report of the Committee to Study the Constitution and Bylaws to the 1959 Session of the House of Delegates was in three parts.

The first part had to do with changes in the Bylaws. The present Constitution and the Bylaws as revised at the 1959 Annual Session appear in their entirety in this issue, starting on page 1599.

The second part had to do with the development of a Model County Society Bylaws. The House of Delegates approved this recommendation without change. Copies of this Model County Society Bylaws are on file in the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville, Kentucky, and are available for the asking.

The third part had to do with the proposed rewriting of the Constitution, the purpose of which is to remove inconsistencies and clarify definitions, in addition to changing the name of the Executve Body of the Association. The proposed Constitution, which will be voted on at the 1960 Session, follows in its entirety.

Constitution of The Kentucky State Medical Association

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Meaning of the Term "County Societies"

Constitution

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies but the House of Delegates shall have authority to adopt such Bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the Bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-elect, three Vice-Presidents, a

Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee from each District that may be established, and such other officers as may be provided for in the Bylaws.

Section 2. The duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt Bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the Bylaws.

Section 2. Delegates shall be members of and elected by component societies in such manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the Bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable. Provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select, including but not limited to an equal per capita assessment by class of membership, upon each component county society. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" means those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

Recommendations, Reference Committee No. 4

Constitution: The changes in the Constitution of the Kentucky State Medical Association were discussed and approved as written for next year's action by the House of Delegates.

Mr. Speaker, I move the adoption and implementation of this section of the report.

The motion was seconded and carried.

Report of The Committee on The Corporate Practice of Medicine

During the past year no referrals of business were made to this Committee and no meetings were held.

With the formation of the Committee on Third Party Medicine by the Council late in the 1957-58 Associational year, it would appear that the need for this Committee has been dissipated. As a result it is suggested that the Committee on the Corporate Practice of Medicine be dropped.

Committee on The Corporate Practice
Of Medicine
Clements W. Air, M.D., Ludlow
Rankin C. Blount, M.D., Lexington
Marion O. Crowder, M.D., Owensboro
Stephen R. Ellis, M.D., Fairdale
John T. Giannini, M.D., Louisville
B. B. Holt, M.D., Ashland
Burl Mack, M.D., Pewee Valley
George P. Archer, M.D., Prestonsburg, Chrm.

Recommendations, Reference Committee No. 4

The report of the Committee on the Corporate Practice of Medicine which suggested that the Committee be dropped was approved since there is another committee on third party medicine formed by the Council which will fulfill the function of this Committee.

Mr. Speaker, I move the adoption and implementation of this section of the report.

The motion was seconded and carried.

Report of The Advisory Committee to Selective Service

Again the Advisory Committee to Selective Service has a very brief report to make on activities in the year 1958-59. We have not seen fit to call a meeting of the complete Committee, having been able to handle our problems by telephone and mail with the usual fine cooperation from our old, and your present, Executive Secretary, Mr. Joseph P. Sanford. Some of our few problems have been very difficult to solve in all fairness to the medical men and communities involved. In all cases Kentucky has been given the first consideration, with the Armed Forces coming in for a fair but second consideration. Possibly the visit between Messrs. Eisenhower and Khruschev will make further activities of our Committee unnecessary, and poor reports of this kind a thing of the past.

Once more, may we express our great appreciation to the Council and those members of the medical profession in Kentucky who have given such fine cooperation to this unwelcome work.

Advisory Committee To Selective Service
Sydney G. Dyer, M.D., LaCenter
J. Duffy Hancock, M.D., Louisville
Charles B. Billington, M.D., Paducah
O. B. Coomer, D.D.S., Louisville
F. E. Hull, D.V.M., Lexington
Frank W. Jordan, D.D.S., Louisville
Lula B. McClain, R.N., Louisville
Sam A. Overstreet, M.D., Louisville
Marcus Randall, D.D.S., Louisville
L. O. Toomey, M.D., Bowling Green
Russell E. Teague, M.D., Louisville
Glenn U. Dorroh, M.D., Lexington
A. Clayton McCarty, M.D., Louisville
Chairman

Recommendations, Reference Committee No. 4

The Report of the Advisory Committee to Selective Service stating that all cases in Kentucky had been given the first consideration, with the Armed Forces coming in for a fair but second consideration, was approved.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution D

Amendments to Bylaws, Section III, Chapter VI

The Vice Presidents shall be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties as Vice Presidents, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Delegation, Fayette County Medical Society

Recommendations, Reference Committee No. 4

The Committee did not approve of Resolution "D" as presented and offers an amended resolution in its stead to read as follows:

"The Vice Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amount as may be available out of the sum appropriated in the annual budget for the travel expenses of the President."

This amendment is to be added at the end of Section 3, Chapter VI, of the Bylaws.

Mr. Speaker, I move the adoption and implementation of this section of the report.

The motion was seconded and carried.

Resolution L

To: House of Delegates, Kentucky State Medical Association
From: Spencer County Medical Society

WHEREAS, the Spencer County Medical Society is presently in the Fourth Councilor District, and

WHEREAS, the hospitals and medical society to which the physicians in Spencer County are members are in the Seventh Councilor District, and

WHEREAS, it would be more advantageous for the physicians in Spencer County to be in the Seventh Councilor District;

BE IT THEREFORE RESOLVED, that Chapter 4, Section 13, of the Bylaws be amended to delete the word "Spencer" from District Four and add the word "Spencer" to District Seven.

Recommendations, Reference Committee No. 4

Resolution "L," transferring Spencer County from District 4 to District 7, was approved.

Mr. Speaker, I move the adoption and implementation of this section of the report.

The motion was seconded and carried.

I move you, Sir, Mr. Speaker, the adoption of the report as a whole.

The motion was seconded and carried.

Reference Committee No. 4
Robert S. Dyer, M.D., Louisville, Chairman
Richard Rust, M.D., Newport, Vice Chairman
Robert W. Fidler, M.D., Flemingsburg
Donald Chatham, M.D., Shelbyville
William H. McKenna, M.D., Mt. Sterling

REFERENCE COMMITTEE NO. 5

O. Leon Higdon, M.D., Chairman

Miscellaneous Business

(Excerpts from the report of the Delegates to the AMA to the 1959 Session of the House of Delegates —referred to Reference Committee No. 5.)

6. All state medical associations are urged to consider the advisability of carrying out relative value studies along the lines of those which have been made in California and other states.

2. All medical society sponsored prepayment health plans, such as the Blue Shield plans, are urged to expand their coverage and to increase the scope of their services; to try to prevent an increase in closed panel systems of practice; as well as to render a better service to the public.

3. State Medical Associations are requested to initiate and sponsor legislative activity to eliminate cancer quackery.

Recommendations, Reference Committee No. 5

On Report No. 8 of the Delegates to the American Medical Association, Reference Committee No. 5 has considered on Page 3, Item 6, all State Medical Associations are urged to consider the advisability of carrying out relative value studies along the lines of those which have been made in California and other states. This directive of the American Medical Association to our House of Delegates has been considered and your committee realizes that this idea is new to most of our members and will need much study and consideration. Further in this report will be seen the value of implementing the suggestion of the Physicians Mutual that each physician cooperate in reporting his usual charge for each service when an insurance report is filed. In this manner a vast amount of valuable information will have been received along the lines of this relative value study.

Also, on the Report of the Delegates of American Medical Association, page 2, item 2, has been considered by this Committee and it is further recommended that all medical-society-sponsored prepayment health plans such as the Blue Shield Plan are urged to expand their coverage and to increase the scope of their services; to try to prevent an increase in closed panel systems of practice; as well as to render a better service to the public. And on page 2, item No. 3 of the same report State Medical Associations are requested to initiate and sponsor legislative activity to eliminate Cancer Quackery. Your committee recommends that the House of Delegates shall instruct the Legislative Committee to cooperate with the Board of Health in the preparation of such legislative activity.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Medico-Legal Administrator

During the past year this office has been approached in connection with three professional liability suits. One of these suits has been disposed of, a second is pending and no information has been received on the third since the initial notification.

Medico-Legal Administrator
J. D. Gordinier, M.D.,
Louisville

Recommendations, Reference Committee No. 5

Mr. Speaker, Reference Committee No. 5 has reviewed the Report of the Medico-Legal Administrator to the 1959 Session of the House of Delegates which is in substance that only three professional liability suits were reported. One of the suits has been disposed of, the second suit is pending and no information has been received on the third suit.

We wish to commend Doctor Gordinier and his committee for their efforts in behalf of our members involved in such unpleasant experience. We are happy that the number is so small.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The KSMA Advisory Commission to Blue Shield

In the Annual Report of the Board of Directors of Kentucky Physicians Mutual given by Doctor Duffy Hancock to the House of Delegates of the Kentucky State Medical Association at the 1958 Annual Meeting, the following recommendation was made: "The Board of Directors of the Kentucky Physicians Mutual, Inc., recommend that the President of the Kentucky State Medical Association appoint a Blue Shield Advisory Committee from the membership of the Association to study the problems relative to the needs of the people for prepayment of medical care; to get the answers, and to make recommendations as to how medical care can be properly financed on a prepayment basis."

This recommendation was approved by the House of Delegates and after consultation with other members of the profession, President Robertson appointed the following twenty-one members of the Kentucky State Medical Association to serve on the new Advisory Commission to Blue Shield:

W. Vinson Pierce, M.D., Covington, Chmn.	Urologist — Physicians Mutual Board of Directors
Richard R. Slucher, M.D., Louisville	Internist
Malcom D. Thompson, M.D., Louisville	Surgeon
Harry S. Andrews, M.D., Louisville	Pediatrician
Garnett J. Sweeney, M.D., Liberty	General Practitioner — Chmn., Blue Shield Long Range Planning Chmn. Blue Shield KSMA Council
C. Walker Air, M.D., Covington	General Practitioner
Alfred O. Miller, M.D., Louisville	Radiologist
William R. Willard, M.D., Lexington	Dean, U of K College of Medicine
J. Murray Kinsman, M.D., Louisville	Dean, U of L School of Medicine
Louis M. Foltz, M.D., Louisville	Psychiatrist
Chester M. Blanton, M.D., Paducah	Dermatologist
Robert A. Orr, M.D., Mayfield	Ob-Gyn.
Arthur H. Keeney, M.D., Louisville	Ophthalmologist
Fred M. Williams, M.D., Louisville	Anesthesiologist
James T. McClellan, M.D., Lexington	Pathologist
William K. Massie, M.D., Lexington	Orthopedic
Donald B. Thurber, M.D., Louisville	Industrial
Willard Buttermore, M.D., Corbin	ENT
Hugh Houston, M.D., Murray	Internist, Blue Cross Board of Directors
Sam A. Overstreet, M.D., Louisville	Internist — Editor of KSMA Journal — Advisory Committee to Blue Cross
J. C. Weeter, M.D., Louisville	Plastic Surgeon

As can be seen, the membership of the Commission was chosen so as to give proper representation to the various specialty groups and to the general practice group, and also to insure that the various geographical areas of the state would be well represented.

An Executive Committee, composed of the first eight men whose names are listed above, was selected to do the ground-work for the Commission, and to organize and screen the material to be considered by the full membership of the Commission.

There have been two meetings of the Executive Committee which met on January 22, 1959 and on March 19, 1959. Meetings of the full Commission were held on April 30, 1959 and on July 2, 1959, with a majority of the members attending each meeting.

Several problems of immediate and of long range significance were considered by the Commission at

these meetings. Among them were the request of the Kentucky Dental Association that the Kentucky Physicians Mutual should include in its schedule of benefits, several procedures not currently covered; and that payment for services should be made directly to the dentist, rather than to the patients. These requests were referred to the Board of Directors of the Kentucky Physicians Mutual, with recommendation that direct payment be allowed to the dentists, and that further study be given to the request for additional coverage for dental procedures.

Two problems of great concern to the members of the Kentucky State Medical Association have demanded most of the time and thought of the meetings of the Commission and of its Executive Committee thus far.

The first of these is the matter of providing voluntary health insurance plans for individuals over 65 years of age who have low incomes and limited resources. The American Medical Association, at its meeting in Minneapolis in December 1958, urged that constituent and component medical societies, as well as physicians everywhere, expedite the development of effective prepayment plans for the old-age, low income group, and that physicians agree to accept a level of compensation for medical services rendered to this group, which will permit the development of such plans at rates which the recipients can afford to pay.

The other problem was that of implementing a directive of the Council of the Kentucky State Medical Association. At the meeting of the Council which was held on April 2, 1959, the Medical Advisory Committee to Blue Shield was instructed to "work with the staff of Kentucky Physicians Mutual in the development of a plan providing coverage on a service basis for the people in Kentucky."

At its meeting held on April 30, 1959, the Advisory Commission was in wholehearted agreement as to the need and desirability of providing an effective prepayment plan for the old-age, low-income group. There was much discussion concerning the advisability of adopting service type plans for this group, as well as for other people in the state having incomes below certain specified levels. It was decided to defer decision on these items until a later meeting; and in the meantime, the staff of Kentucky Physicians Mutual was requested to develop a service plan or plans for consideration by the Commission, and to give further thought to changing the schedule of benefits in the contract for the old-age group, in areas where the physicians concerned had expressed dissatisfaction with the benefits which had been proposed in the original contract. It was suggested by several members of the Commission that at the next meeting a physician who has had long experience in a service plan should be invited to meet with the Commission to discuss the advantages and disadvantages of a service plan as opposed to an indemnity plan.

At the following meeting of the Advisory Commission to Blue Shield, which was held in Louisville on July 2, 1959, Mr. Richard Nelson of the AMA Headquarters staff; and Doctor Ira Layton of Kansas City, Missouri, met with the Commission by special invitation. Mr. Nelson summarized to the Commission the work which has been done in other states in developing prepaid coverage for the old-age group, and the current status of such plans. Doctor Layton, who is Vice-President of a large service type Blue Shield Plan in Kansas City, Missouri, presented his reasons for believing that a service plan is preferable to an indemnity plan, both for the members of the profession and for the participants in the plans.

Following these talks, there was a question and answer period in which the members of the Commission expressed their own viewpoints and asked questions of the visitors. The Staff of Kentucky Physicians Mutual then presented two service plans, having different income ceilings; and also presented a revised contract for the old-age coverage, in compliance with the previous request of the Commission.

The members of the Commission who were present, by a majority of 9 to 2, voted to recommend to the Council of the KSMA that the service plans which the staff of Kentucky Physicians Mutual had developed, at the request of the Commission, be adopted; and that the plan for the old-age, low-income group be adopted as a service plan. These recommendations were presented to the Council of the KSMA at its open meeting held in Louisville on July 30, 1959.

Because of the controversial nature of the proposals involved, and because it was felt that the members of the Kentucky State Medical Association would need more time to acquaint themselves with the differences between services and indemnity plans, and with the advantages and disadvantages of both types of plans; the Council unanimously voted to defer consideration of the service plan to a special session of the House of Delegates, to be held in the near future. The Medical Advisory Commission was authorized to work with the staff of Kentucky Physicians Mutual in developing a plan for the coverage of older people, age 65 and over, who have low income and limited resources, on an *indemnity* basis.

Such a plan was considered and adopted by the Advisory Commission at its meeting on August 20th, 1959, and is to be presented to the Board of Directors of Kentucky Physicians Mutual at its next meeting. Copies of the contract will be mailed to all of the physicians in our state, when it has finally been approved.

The members of the Medical Advisory Commission wish to express their sincere thanks to Mr. Lane Tynes, Executive Director of Kentucky Physicians Mutual, and to his staff, who have cooperated to the fullest extent in developing the plans which were requested by the Commission and in carrying out the suggestions of the Commission regarding these plans. The Medical Advisory Commission is also deeply grateful to Mr. J. P. Sanford and to the members of the KSMA Headquarters staff for their efficient and enthusiastic help during the past year.

Supplemental Report of The KSMA Advisory Commission to Blue Shield

The Commission met on August 20 after the annual report of the Commission to the House of Delegates had been written. The Commission wishes to submit the following two recommendations as a supplemental report.

The Commission, being eager to make sure that medicine discharges its full responsibility to the low-income members of our senior citizens' group and at the same time being conscious of its responsibility to promote and maintain the system of medicine that makes this the healthiest country in the world, has given careful consideration to this problem.

The Commission sees both advantages and disadvantages to the service type coverage, just as it sees advantages and disadvantages to the indemnity type protection. Because a considerable number of the profession have indicated it has been their practice to provide their services to low-income groups among the aged at a reduced fee, it is recommended that the profession as a whole make every effort to subscribe to the following recommendation.

"Doctor Buttermore moved that Medical Advisory Commission to Blue Shield recommend to the House of Delegates that the House of Delegates urge that wherever possible physicians accept as full payment the allowances allowed by the special indemnity plan for services rendered to patients 65 years of age and over having incomes of less than $1500 annually for single person or $2500 annually for couple and having resources less than $15,000 single person, $25,000 for a couple."

The plan, which the Council of the KSMA has authorized and directed the Medical Advisory Commission to Blue Shield to prepare (in cooperation with the Staff of Kentucky Physicians Mutual) and which will be presented to the Board of Directors of Kentucky Physicians Mutual for their consideration at the Meeting on September 21, 1959, is presented in this supplemental report for informational purposes only.

KENTUCKY PHYSICIANS MUTUAL, INC. PROPOSED BLUE SHIELD IDEMNITY PROGRAM FOR THE AGED

A. *Eligibility*
1. Available to unemployed persons 65 or more years of age, who are not eligible for group membership, with limited resources and whose annual incomes do not exceed $1,500.00 for single persons, and $2,500.00 for husband and wife and resources of less than $15,000 single, $25,000 family.
2. Each member must enroll on an individual basis.

B. *Benefits*
1. Surgical and Anesthesia. . .
Allowances for surgery and anesthesia shall be 80% of the Kentucky Physicians Mutual Standard Certificate Schedule of Allowances.
2. In-Hospital Medical. . .
Allowance for In-Hospital Medical shall be $15.00 for the First day, $5.00 per day for the next five days, and $3.00 per day for the remainder of 70 days.
3. Diagnostic X-ray. . .
Diagnostic X-ray schedule if provided in a hospital; or in the hospital out-patient department or doctor's office if hospitalization follows immediately.
4. Radiation Therapy. . .
Allowances shall be 80% of the Kentucky Physicians Mutual Standard Certificate scheduled allowances.

C. *Exclusions*
1. All exclusions in the Standard Certificate would apply, including 12 months' waiting period for pre-existing conditions.

D. *Rate*
1. To be ascertained.

The Commission discussed at length the advantages of knowing to what degree the new certificate to cover the senior citizens of low income was meeting the need. After much discussion, the Commission adopted the following recommendation to the House of Delegates—

"Doctor Massie moved that the Medical Advisory Commission recommend to the House of Delegates that each physician list his total fee for each service rendered on the Claim Form submitted to the Kentucky Physicians Mutual so that valuable statistics can be obtained—(a) On the percentage of physicians accepting the Kentucky Physicians Mutual's Indemnity Allowance as payment in full for services rendered to patients over the age of 65, and (b) So that a relative value scale of fees for various services actually in practice currently in Kentucky can be obtained."

Advisory Commission to Blue Shield
Richard R. Slucher, M.D., Louisville
Malcom D. Thompson, M.D., Louisville
Harry S. Andrews, M.D., Louisville
Garnett J. Sweeney, M.D., Liberty
C. Walker Air, M.D., Ludlow
Alfred O. Miller, M.D., Louisville
William R. Willard, M.D., Lexington
J. Murray Kinsman, M.D., Louisville
Louis M. Foltz, M.D., Louisville
Robert A. Orr, M.D., Mayfield
Arthur H. Keeney, M.D., Louisville
Fred M. Williams, M.D., Louisville
James T. McClellan, M.D., Lexington
William K. Massie, M.D., Lexington
Donald B. Thurber, M.D., Louisville
Willard Buttermore, M.D., Corbin
Hugh Houston, M.D., Murray
Sam A. Overstreet, M.D., Louisville
Chester M. Blanton, M.D., Paducah
John C. Weeter, M.D., Louisville
W. Vinson Pierce, M.D., Covington
Chairman

Recommendations, Reference Committee No. 5

Mr. Speaker, the Reference Committee wishes to report on the KSMA Advisory Committee to Blue Shield as follows:

Reference Committee No. 5 considered the report of the KSMA Advisory Committee to Blue Shield (Report No. 20) and the supplemental report of the Advisory Committee to Blue Shield.

It was noted that the Advisory Commission to Blue Shield at the direction of the Council of the KSMA had worked with the staff of Kentucky Physicians Mutual to develop a service type of Blue Shield Plan which was presented to the Council for its consideration at its open meeting on July 30. Because of the controversial nature of the proposals involved and because it was felt that the members of the Kentucky State Medical Association would need more time to acquaint themselves with the advantages and disadvantages of both the service and the indemnity type of Blue Shield Plan, the Council voted to defer consideration of the service plan to a special session of the House of Delegates to be held at some future time. This Reference Committee wishes to commend the Council for its wisdom and judgment in deferring action on the service plan, and recommends that an intensive program of education to acquaint the members of the State Association with the differences between service and indemnity plans be conducted through the medium of the Journal of the KSMA and suggest other means of communication as may be expedient before taking a vote of the members of the House of Delegates on this question.

The special indemnity plan for people over 65 having low income and limited resources which had been developed by Kentucky Blue Shield at the request of the Council of the KSMA was considered. It would appear that in a large portion of cases the allowances which were made by this plan for the particular service involved would be comparable to the fees which most physicians would charge these patients under the given circumstances.

Our Reference Committee has considered the recommendation of the Medical Advisory Commission to Blue Shield that the House of Delegates urge that wherever possible physicians accept as full payment the allowances made by the special indemnity plan for services rendered to people over 65 years of age having incomes of less than $1500.00 annually for a single person or $2500.00 annually for a couple and having resources less than $15,000.00 for a single person or $25,000.00 for a couple. Our Reference Committee concurs in this recommendaiton to the House of Delegates.

The Reference Committee also considered the second recommendation of the Medical Advisory Commission to the House of Delegates to the effect that each physician list his total fee for each service rendered on the claim form submitted to the Kentucky Physicians Mutual so that valuable statistics can be obtained (A) On the percentage of physicians accepting the Kentucky Physicians Mutual Indemnity allowance as payment in full for services rendered to patients over the age of 65 and (B) So that a relative

value scale of fees for various services actually in practice currently in Kentucky can be obtained.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

The McDowell Home Committee Report

The restoration of the McDowell Home Apothecary Shop, begun in 1957, has been completed and was formally dedicated on August 14, 1959. A brief review of the activities leading up to this restoration is in order. In 1955 the Kentucky State Pharmaceutical Association became interested in restoring the old apothecary shop adjoining the McDowell Home. This was first used by Doctor McDowell as an office and apothecary before he built his home and was the first apothecary west of the Allegheny Mountains. This old shop was left out when the McDowell Home was restored in 1936 and was rapidly falling apart. The pharmacists bought, for $10,000, the ramshackle brick building next to the shop and deeded it to the KSMA. Slightly more than $20,000 was then contributed by several pharmaceutical manufacturing companies, for the restoration of the shop. This was mostly a single gift from the Eli Lilly Company of Indianapolis.

The shop has been beautifully restored with these funds, under the direction of Mr. Oberwarth of Frankfort. We were fortunate in securing him especially because he was the architect in charge of restoring the home in 1936 and gave the project architectural skill, historical authenticity and loving care. He was assisted in accuracy by an expert in apothecaries of that period, Mr. Griffenhagen of the Smithsonian Institute.

At the present writing, another nationally known pharmaceutical house is interested in equipping the shop with drugs, jars, scales and other materials. These will be originals as far as possible, and careful reproductions where necessary. We are happy to report that this is all being done by experts in the field of apothecaries of the 18th and early 19th centuries.

Financially the McDowell Home is in sound condition. The revenue for the year 1959 is from the following sources:

KSMA	$1500.00	
K. Surg. Soc.	1300.00	
So. Surg. Assoc.	200.00	
Am. Coll. Surg.	500.00	—Memorial to Dan Elkin, M.D.
Admissions to Home, etc.	700.00	
	$4200.00	

This is barely enough to maintain the property and grounds, provide a full-time hostess and pay for utilities.

It is the present plan of this Committee to solicit annual gifts from other national surgical organizations.

McDowell Home Committee
I. Abell, Jr., M.D., Louisville
L. A. Gray, M.D., Louisville
O. L. Higdon, M.D., Paducah
E. M. Howard, M.D., Harlan
V. G. Kinnaird, M.D., Lancaster
G. M. McClure, M.D., Danville
G. L. Simpson, M.D., Greenville
Dean E. P. Slone, Lexington
Mr. George Grider, Danville
Mr. Sterling Coke, Lexington
C. A. Vance, M.D., Lexington
Chairman
F. M. Massie, M.D., Lexington
Co-Chrmn.

Recommendations, Reference Committee No. 4

The report of the McDowell Committee is worthy of your study. It calls to our attention the restoration of the McDowell Home Apothecary Shop, a program which began in 1957. Many people, many organizations and much money and effort have been expended in this program. Especially, would we like to call your attention to the many years of study and devotion given this committee effort by Doctor C. A. Vance, Chairman.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of Representative to Conference of Presidents and Other Officers of State Medical Associations

The Conference of Presidents and Other Officers of State Medical Associations Meeting was held at the Traymore Hotel in Atlantic City, Sunday afternoon, June 7. A number of Kentuckians were present including our delegates, alternates and Headquarters Staff representatives.

Irvin Abell, Jr., M.D., President-elect, was kind enough to represent me at this meeting, which included four excellent presentations in the field of socio-economics.

It is recommended that the KSMA encourage as many of its members as possible to attend the 1960 Conference at Miami.

Robert W. Robertson, M.D., Paducah
Representative

Recommendations, Reference Committee No. 5

The report of the Representative to Conference of Presidents and Other Officers of State Medical Associations is accepted in full as reported by the President, Doctor Robertson.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the Board of Directors of Kentucky Physicians Mutual, Inc.

The Board of Directors of the Kentucky Physicians Mutual, Inc. presents this annual report to the Kentucky State Medical Association. It is an analysis of the 10th year of operation and shows what the continued growth of this Blue Shield Plan means to the people and the physicians of Kentucky.

The cost of medical care continues to rise. It is imperative that the people have some means of prepaying for care in monthly amounts they can afford. Your Blue Shield Plan has attempted to meet this problem in cooperation with Blue Cross. The basic surgical plan on which we have continued to hold the line, from the standpoint of costs, can now be expanded by riders and, also, by preferred surgical allowances. During the year the commission appointed by the KSMA under the leadership of Dr. Vinson Pierce has explored the needs of the people and will make several recommendations at your annual meeting. The most concrete recommendation is the provision of a plan for aged persons in the low-income, low-resource category. It is contemplated that this plan will be put into effect the latter part of November, both by Blue Shield and Blue Cross. At that time you will receive all details regarding it.

During the past year 54,726 persons have been enrolled. As of June 30, 1959, Blue Shield had 590,776 members. The Plan is in excellent financial condition, and due to the elimination of allowances for minor diagnostic and other procedures, has operated in the black since the first of the year. During

the first six months of 1958, the Plan lost $71,969. During the first six months of 1959, $83,361 was added to reserves. This makes an improvement of almost $155,000. During the first six months physicians received $2,468,134 from the Plan. Total payments for the year 1959 will run well over $5,000,000 paid to Kentucky physicians.

Your Board of Directors, list of which is attached, pledges itself to continued efforts in solving the problem of financing medical care for the people of Kentucky.

J. Vernon Pace, M.D., President
J. P. Sanford, Secretary

Recommendations, Reference Committee No. 5

The report of the Board of Directors of the Kentucky Physicians Mutual has been studied by your Reference Committee and we feel that this House of Delegates should recognize the fine work which has been done and that the Board of Directors be commended for the pledge to continue efforts in solving the problem of financing medical care of the people of Kentucky.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Committee to Study Relations With Voluntary Health Groups

The Committee to Study Relations with Voluntary Health Groups held one meeting during the year on July 23 at the Medical Arts Building, Louisville, Kentucky.

This committee has as its primary function the stimulation of interest by the physicians in the voluntary health groups so that if they are invited to participate in such groups they may lend their assistance and thinking. It is thought that this would be good both from the standpoint of public relations for the voluntary health fund and for the physicians.

It was the unanimous opinion of the committee that all KSMA members should interest themselves in worthy voluntary health organizations at both the state and local level as effective physician participation is not only expected by the public, but doctors have much to contribute both in the interest of the organization and the advancement of their respective fields in medicine.

It is also the opinion of this committee that any physician who is invited to participate in a voluntary health organization should be well aware of the objectives and aims of this organization as well as knowing who the interested laymen are in such an organization. This should prevent much duplication of effort and cut down the overlapping of interest which occurs from time to time in different voluntary health organizations.

Also, we recommend that the Kentucky State Medical Association notify the voluntary health groups that we have a committee which is set up to work in this general area and that it is available to lend its assistance and cooperation in this field.

Committee to Study Relations With
Voluntary Health Groups
M. F. Beard, M.D., Louisville
C. M. Bernhard, M.D., Louisville
E. McDaniel, M.D., Louisville
K. A. Fischer, M.D., Louisville
L. M. Foltz, M.D., Louisville
T. M. Marshall, M.D., Louisville
L. H. Segerberg, M.D., Louisville
L. A. Taugher, M.D., Louisville
R. M. Denham, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 5

This Committee has as its primary function the stimulation of interest by the physicians in the Voluntary Health Groups so that if they are invited to participate in such groups they may lend their assistance and thinking. It is thought that this would be good both from the standpoint of public relations for the voluntary health fund and for the physicians. It is the unanimous opinion of the committee that all KSMA members should interest themselves in worthy voluntary health organizations at both the state and local level as effective physician participation is not only expected by the public, but doctors have much to contribute both in the interest of the organization and the advancement of their respective fields in medicine. It is recommended that the KSMA notify the Voluntary Health Groups that we have a committee which is set up to work in this general area and that it is available to lend its assistance and cooperation in this field.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution C

WHEREAS, there is ample evidence of many unnecessary admissions to hospitals and unnecessary prolongation of hospital stays, and

WHEREAS, the constantly rising costs of hospital and medical care is a matter of deep concern to our Association, and

WHEREAS, if these two problems are not solved on a voluntary basis consistent with sound administrative and medical practice, the costs of voluntary prepayment plans will be priced out of the reach of those who need them most;

THEREFORE, the Medical Advisory Committee of the Kentucky State Medical Association to Blue Cross recommends to the House of Delegates of the Kentucky State Medical Association that the medical staffs in all hospitals set up admission and review committees to accomplish the following:

1. See that only persons who need care are admitted to hospitals;
2. Make sure that patients remain only as long as hospital-type care is required;
3. Plan so that necessary tests and consultations in the hospitals are completed quickly, eliminating every possible delay in the treatment of patients;
4. Make the most efficient use of modern hospital facilities.

Medical Advisory Committee
Sam A. Overstreet, M.D., Chairman
Gabe A. Payne, Jr., M.D., Delegate
John J. Sonne, M.D., Delegate
Willard M. Buttermore, M.D., Delegate

Recommendations, Reference Committee No. 5

Resolution C has been submitted by the Medical Advisory Committee to the Blue Cross, namely, that the House of Delegates shall recommend to the Medical Staff of all Kentucky hospitals that a committee be set up in each hospital to review and accomplish the following:

(1) See that only persons who need care are admitted to hospitals.
(2) Make certain that patients remain only as long as hospital type care is required.
(3) Plan so that necessary tests and consultations in the hospitals are completed quickly, eliminating every possible delay in the treatment of patients.
(4) Make the most efficient use of modern hospital facilities.

Mr. Speaker, your Reference Committee No. 5 recommends the adoption of this resolution in order

that the continually rising costs of hospital and medical care and the many unnecessary admissions and prolongation of hospital stays be avoided.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution H—Allen County Medical Society

The two resolutions adopted by the Allen County Medical Society at meeting on September tenth are hereby presented to the House of Delegates for action.

RESOLVED, that the House of Delegates of the 1959 session of the Kentucky State Medical Association go on record as being opposed to the adoption of any 'service plan' for any age group by the Kentucky Physicians Mutual, Inc.

Recommendations, Reference Committee No. 5

The Allen County Medical Society Resolution H, No. 1 resolves that the House of Delegates of the 1959 Session of the Kentucky State Medical go on record as being opposed to the adoption of any service plan for any age group by the Kentucky Physicians Mutual, Inc. Your Committee has had a thorough discussion of this resolution and we wish to report that we feel that such an action is premature and ill advised. We can only resolve our thinking in this problem if such a plan is thoroughly discussed and the general plan widely publicized and component medical societies study this problem. It is only by such a thorough study and consideration throughout the state that we can learn the true wish of all of our members. Your Committee recommends that this resolution not be adopted.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Resolution "I"

RESOLVED, that the House of Delegates of the 1959 meeting of the Kentucky State Medical Association instruct the Council of the Kentucky State Medical Association not to call an interim meeting of the House of Delegates of the Kentucky Medical Association before the next regular Meeting in 1960, for the purpose of considering the adoption of a 'service plan' for Kentucky Physicians Mutual, Inc.

Allen County Medical Society
A. O. Miller, M.D., President
John W. Meredith, M.D., Secretary
Owen Davis, M.D., Delegate
John W. Meredith, M.D., Alternate Delegate

Recommendations, Reference Committee No. 5

Resolution I deals with the Allen County Medical Society Resolution No. 2, which resolves that the House of Delegates of the 1959 meeting of the Kentucky State Medical Association instructs the Council of the Kentucky State Medical Association not to call an interim meeting of the House of Delegates of the Kentucky State Medical Association before the next regular meeting in 1960 for the purpose of considering the adoption of a service plan for Kentucky Physicians Mutual, Inc.

Reference Committee No. 5 has been advised by our Legal Counselor, Mr. Davis, that this resolution is out of order, therefore, no action should be taken.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole.

The motion was seconded and carried.

Reference Committee No. 5
O. Leon Higdon, M.D., Paducah, Chairman
L. H. Segerberg, M.D., Louisville, Vice Chairman
Wilber R. Houston, M.D., Erlanger
George E. Clark, M.D., Brandenburg
Willard Buttermore, M.D., Corbin

REFERENCE COMMITTEE NO. 6

N. Lewis Bosworth, M.D., Chairman

Reports of Miscellaneous Business

Report of the Advisory Committee to the Editor

Our Committee has held one meeting during the past associational year. The Agenda included numerous items for the consideration of the Committee, items designed to improve the usefulness and attractiveness of the Journal of KSMA.

More important matters acted upon were the recommendation of a new cover page for the Journal; the inclusion of a new department—the Insurance Page; making permanent the department furnished by the Committee on Maternal Mortality and the revamping of the Annual Meeting section of the Journal of KSMA.

Your Advisory Committee would remind all members of KSMA that if our Journal is to maintain the high position it presently enjoys and to increase its usefulness to our members, we must receive scientific material of highest caliber. So, we urge more members to write and submit scientific papers on appropriate subjects for consideration for publication.

Our Committee is impressed with the interest in and grasp of problems our Editor, Sam A. Overstreet, M.D., and Associate Editor, George W. Pedigo, M.D., have shown. The House will be interested to know they meet each Monday morning at 7:30 with the Managing Editor and his assistant, thus providing close supervision and adequate contact, in matters pertaining to the publishing of the Journal.

Advisory Committee To The Editor
James E. Hix, M.D., Owensboro
Francis M. Massie, M.D., Lexington
Richard J. Rust, M.D., Newport, Chairman

Recommendations, Reference Committee No. 6

This is the report of the Advisory Committee to the Editor to the 1959 session of the House of Delegates. We wish to commend this Committee for the foresight in bringing about important changes as follows:

1. New Cover Page for the Journal of the KSMA.
2. Insurance Page for the Journal of the KSMA.
3. Making permanent the department furnished by the Committee on Maternal Mortality.
4. Revision of the Annual Meeting section of the Journal of the KSMA.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Emergency Medical Services Committee

There were no formal meetings of this committee during the year 1959, since it had been decided in the prior years that emergency service should be a county function rather than a state function.

During this period, however, the legal liability of physicians furnishing service and mobile care under authorization of duly constituted Civil Defense authorities was investigated and it was the opinion of the legal counsel that they would be excluded from liability under the Civil Defense Act of Kentucky.

Emergency Medical Services Committee

T. L. Adams, M.D., Lexington
F. J. Halcomb, M.D., Scottsville
E. F. Hall, M.D., Owensboro
S. M. Hunter, M.D., Louisville
R. E. Reichert, M.D., Covington
C. F. Wood, M.D., Louisville
E. K. Martin, M.D., Frankfort
W. B. Haley, M.D., Paducah, Chairman

Recommendations, Reference Committee No. 6

We wish to point out again, the statement made in this report which is as follows, "It was the opinion of the legal counsel that physicians would be excluded from liability under the Civil Defense Act of Kentucky."

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Advisory Committee to The Woman's Auxiliary of The Kentucky Medical Society

This committee has not held a meeting during the past year. However, we have corresponded and have acted on all problems that have been presented.

We wish to thank Mrs. Jess T. Funk, President of the Woman's Auxiliary, for the splendid job she has done, and we especially commend the Auxiliary for the effort put forth and the work they have done in the high schools of the state on Driver Education.

With the emphasis now being made on the care of the aged, we are hoping that the Auxiliary will lend their support to this problem.

Advisory Committee to The Woman's Auxiliary
Of The Kentucky State Medical Association

Charles B. Billington, M.D., Paducah
R. Ward Bushart, M.D., Fulton
L. O. Toomey, M.D., Bowling Green, Chairman

Recommendations, Reference Committee No. 6

There were no meetings and no important announcements.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The Committee on Medical Services

The Committee on Medical Services consists of fourteen committees. Nine of these had no meeting during the last year. Any question or problem was taken care of by the chairmen. The five who had meetings are reported individually.

1. CRIPPLED CHILDREN—K. Armand Fischer, M.D., Louisville, Chairman.

During the year the Kentucky Crippled Children Commission employed a new Director, Dr. Marjorie K. Smith, who has given a detailed report to this committee on the activities of the commission during the calendar year 1958. There have been no drastic changes during the year.

Since the coming of the Salk Vaccine, the number of acute polio cases has markedly dropped; and, likewise, the polio case load in our Crippled Children's Hospitals has dropped. There is still a large number of patients, however, who need surgery.

It is being reported that perhaps the National Foundation for Infantile Paralysis is going to withdraw all monetary support for the care of the polio cripples from hospitals. As you know, for a while they did pay a small fee to the surgeons who took care of these cases. Now they have practically withdrawn all support from this program. The Kosair Crippled Children's Hospital and other crippled children's hospitals for many years have received a great amount of money to help support their programs, because they took care of poliomyelitis cases and helped with the cost of reconstruction work. If money is shortly to be withdrawn altogether from their support, the physicians of Kentucky may have to ask and help with the proposals to the coming legislatures for an increase in the funds for the care of crippled children.

2. DIABETES—R. J. Hoffman, M.D., South Fort Mitchell, Chairman.

The committee met in Louisville, April 16, to study the results of the 1958 Drive and plan for the 1959 Drive. Here are some of the more pertinent facts.

(1) 90,430 free urine sugar tests were made, as compared to 52,400 in 1957.
(2) These tests yield 175 newly proved Diabetics, as compared to 137 in 1957.
(3) County participation is still far from 100%.
(4) Publicity, as received by newsclippings, continues to be excellent; in fact, probably exceeds all other activities of the KSMA.

The Committee still feels its most challenging job is to sell the drive to all county societies. To further this end, the committee voted, with the approval of the Editor, to have a full page ad in the October issue of the KSMA journal explaining the ADA, the Diabetes Drive, etc. It is hoped that this will overcome some misunderstanding.

The Chairman also would like to respectfully suggest that the chairmanship of this committee be rotated every two years, to members of the committee for different areas of the state.

3. AGED—Robertson O. Joplin, M.D., Louisville, Chairman.

The Committee on Problems of the Aged met on February 5, 1959, to discuss one of medicine's foremost problems, with the realization that what we do today may well avert unpleasant "Forand-type" legislation tomorrow.

Some of the activities of this committee for the year have been:

(a) A letter to all county society secretaries requesting each county society to form a committee on aging and to initiate a program best suited to their local situations.
(b) A letter to all Kentucky hospital staff secretaries offering the help of KSMA in planning any program relating to geriatrics.
(c) Offer of assistance of the KSMA to the Governor's Commission on Aging.
(d) Representation at Joint Council to Improve the Health Care of the Aged Conference in Washington, D. C., on June 12-13.
(e) Consideration of the holding of a state conference on aging in 1960.
(f) News release calling for a re-evaluation of compulsory retirement.
(g) Participation in 1958 Rural Health Conference Panel on Aging and arranging for a panel discussion on Nursing Homes for the Aged at the 1959 Rural Health Conference in Bowling Green.

(h) Urged Senate Sub-committee on Aging to reconsider the role of Federal Government's intervention in this problem; that the solution to the issues should be sought after on a state and local level.

We fully realize this is not a program that has accomplished a complete phase of positive action; however, it is felt this is the first of many steps in the direction toward the Number One objective of the AMA in the field of aging—a stimulation of a more realistic attitude toward aging by all people.

We would like to commend W. B. Troutman, M.D., Louisville, for his zeal and willingness in appearing before groups and discussing the problems relating to the aged and Forand Legislation. Also, may we express our appreciation to the Blue Shield Advisory Commission for its efforts in working on a service plan for the aged in Kentucky and to the Committee on Medical Education and Economics for its efforts and achievements on the medical care bill for the indigent. It behooves all of us to support these measures.

We would recommend to the House of Delegates that all county societies set up committees on the Problems of the Aged and attack this problem on a county level, such as speakers' bureaus, stimulation of interest in aging in local civic clubs, fraternal, religious, and other associated organizations.

With cooperation, we can make strides in this field —provide a quicker and better solution to this problem and avoid the pitfalls of ramrod Forand Legislation.

4. INFANT AND MATERNAL—Robert F. Monroe, M.D., Chairman.

The Sub-Committee for the Study of Maternal Mortality in Kentucky has held to date three luncheon meetings at which time the summarized abstracts of the maternal deaths for the preceding year were reviewed.

The committee has attempted to educate the profession as to the purpose of this committee through the monthly maternal mortality page published in the state journal, where a summary of a maternal death with pertinent constructive comments has been presented.

5. TUBERCULOSIS—Joseph H. Humpert, M.D., South Fort Mitchell, Chairman.

The committee feels that the following items will be of interest:

(1) Dr. Richard Mardis of the Committee, the other KSMA representative on the State Tuberculosis Coordinating Council, is President this year of the State Tuberculosis Coordinating Council.

(2) In February of this year, the recalcitrant patient unit at Hazelwood opened and has been functioning successfully.

(3) A fund of monies has been set up for the purpose of buying medications for indigent tuberculous out-patients who have been medically discharged from T.B. hospitals.

Committee on Medical Services
M. F. Beard, M.D., Louisville
H. W. Shaw, M.D., Louisville
O. H. Salsbery, M.D., Covington
K. A. Fischer, M.D., Louisville
R. Hoffman, M.D., South Fort Mitchell
A. S. Warren, M.D., Lexington
E. S. Dunham, M.D., Edmonton
R. O. Joplin, M.D., Louisville
G. B. Sanders, M.D., Louisville
R. F. Monroe, M.D., Louisville
H. Johnson, M.D., Louisville
G. C. Cunningham, M.D., Ashland
K. D. Leatherman, M.D., Louisville
J. H. Humpert, M.D., South Fort Mitchell
D. M. Cox, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 6

We wish to congratulate this Committee on the excellent job it has done and the things it has accomplished this past year. We recommend that this report be accepted as written.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of The KSMA Adviser to University of Louisville Student AMA Chapter

The Louisville Student AMA Chapter did not contest the KSMA Adviser with any problems the past year.

George W. Pedigo, Jr., M.D., Louisville
KSMA Adviser to University of Louisville
Student AMA Chapter

Recommendations, Reference Committee No. 6

The Louisville Student Chapter of the AMA had no problems to discuss with its adviser. No action taken and no recommendations made.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the Woman's Auxiliary to the Kentucky State Medical Association

The Woman's Auxiliary of the Kentucky State Medical Association sent to the annual convention of the American Medical Association at Atlantic City its full quota of delegates: Mrs. Karl Winter, Louisville; Mrs. Carlisle Morse, Louisville; Mrs. David Cox, Louisville; Mrs. Charles B. Johnson, Russell, president-elect and the presidential delegate. Mrs. Jesse T. Funk, the immediate past president as of September, was appointed Southern Regional Chairman for the "Bulletin."

The Woman's Auxiliary to the Kentucky State Medical Association proudly presents the following brief report of the year's activity.

American Medical Education Foundation

The AMEF chairman kept information alive both by letters and articles in the state publication, Blue Grass News. The total amount contributed was $1502.20.

Today's Health

The subscriptions to Today's Health as of May 1, 1959, totaled 332. The Film Strip concerning Today's Health magazine was shown throughout the State during the past year.

Bulletin

The total number of subscriptions to the Bulletin is now 80. The Bulletin is the official publication of the Auxiliary to the AMA and has been described as the text book of the Auxiliary.

Benevolence

This State Fund was established several years ago. Each year a bit more is added to it until the total is now a substantial sum.

Blue Grass News

This is the State Auxiliary's official publication. It is sent out four times a year to all members, the Advisory Council, to many other state presidents and several of the national officers.

Cancer

The Cancer Essay Contest was held again this year in Lexington at the Fine Arts Building on the University of Kentucky Campus. Four prizes—$100, $50, $25 and $15—were awarded. Forty-two high schools

participated. Ninety-seven schools received literature. Ninety-three people were served lunch by the Fayette County Medical Auxiliary.

Civil Defense

This year the Auxiliary was asked to cooperate with the Woman's Division of the State Civil Defense organization which we did. Material was sent out by the Auxiliary Civil Defense chairman. Nearly all of the County Auxiliaries had at least one program concerning this vital part of our program. One county had a two-minute talk on Civil Defense at each meeting. One county was made aware of the mobile hospital which has been set up in their area. Health cards were given out throughout the state. Three members of one Auxiliary attended nine weeks instruction course on "Home Preparedness."

Community Service

The Voluntary Hours Tabulations sheets returned to our Community Service chairman showed total number of hours given to organizations other than Medical Auxiliaries as 26,412, representing approximately 20% of the membership reporting.

Legislation

It kept all county auxiliaries informed about the Jenkins-Keogh Bill and the Forand Bill. In July, the Regional Legislative Chairman requested that all members write their Congressman and send a copy of their letter to the chairman of the House Ways and Means Committee concerning the Forand Bill; this was done promptly throughout the state. All members were urged to get out the vote in Kentucky's Democratic Primary election in May.

Mental Health

The Mental Health Chairman requested the county auxiliaries to send Christmas cards and gifts to the mental hospitals; this was done. The hospitals were also aided by several auxiliaries giving parties and teas for the personnel. Copies of the booklet, "Mile Stones to Marriage," have been given to several county chairmen.

Safety

Traffic Safety has been uppermost on this committee's work through the year. Slides entitled "A Car of His Own" have been shown to most auxiliaries and several lay groups. Auxiliaries cooperated with other organizations in assisting with road blocks, car safety checks and driver education classes. High schools throughout the state have been urged to form driver education classes; many have done so. The GEMS program now has 222 high school students enrolled.

Rural Health

Under the guidance of the Rural Health Chairman, members throughout the state have assisted in Diabetic Detection Week and Immunization Week.

Heart and Tuberculosis

All the Auxiliaries assisted in their local Heart Drive and on the Tuberculosis Seal Sale and many helped in other ways their local tuberculosis hospitals.

Historian

A new revised complete history of the State Auxiliary since its organization in 1923 will be made available at the September Convention by the Historian.

Para-Medical Careers Recruitment

The AMA film entitled, "Helping Hands for Julie," was used by many groups on their para-medical careers recruitment work. There are now 32 Future Nurses Clubs in the state. One has been converted to a full para-medical career club. There is a total of some $4,000 available in scholarships and loan funds.

Program

The program chairman has served as a clearing house for our own slides and films, Today's Health film strip and safety slides and in sending program and essay literature to county program chairmen. She also worked with the county auxiliaries on their Koda Color Slides project to be used at the September Convention.

President's Report

The President attended as presidential delegate the AMA meeting in Atlantic City in June, presided at four board meetings, post convention last September, the Fall Conference for County Presidents and Presidents-Elect held at Beaumont Inn in Harrodsburg in November, the Spring Board meeting held in the Medical Arts Building, which houses the KSMA offices, in March. Luncheon was served in the American Cancer Society Volunteer room. Pre-convention board breakfast will be held at the Brown Hotel in Louisville at the September, 1959, Convention. Also the President was in attendance at the Chicago Fall Conference for the State Presidents and Presidents-Elect October, 1958, held at the Drake Hotel, the Rural Health Conference held in Louisville in December, and the Rural Health Council Board meeting held in Louisville in July. The President also attended and addressed district meetings in Henderson, Paducah, Ashland, Mammoth Cave and Winchester; installed officers at Owensboro, Lexington and Greenville and attended County Society Officers Conference of KSMA in Lexington in March. It was the privilege of the President to attend a Cancer Essay Awards Contest in Lexington and to present the awards. Was also guest of the Fayette County Auxiliary's annual style show, and was guest of honor at the doctor's dinner at Harlan, and guest at the Indiana Medical Auxiliary House of Delegates Meeting in Fort Wayne in April, and the Indiana workshop for three of their districts in French Lick in May. A President's message for each issue of the Blue Grass News and a short article to the P.T.A. magazine on the Poison Control Centers in Kentucky. Two articles for National Bulletin, History of the year and a written report to the Auxiliary to the AMA.

At the request of the Publishing House for "Pioneer Surgeon, Dr. Ephriam McDowell," letters were sent to councilors, state presidents, McDowell Home Chairman, of practically every state informing them of the existence of this delightful book.

At the request of the National President, Mrs. Underwood made out a form for county auxiliary members to go by in tabulating their hours of service given to organizations other than medical auxiliary. This is a new venture and was called "The Story That Has Never Been Told." The results were published at the AMA meeting in Atlantic City, June, 1959.

Articles, documents and correspondence going out from the President's office were as follows: a quarterly "News Letter" to all county presidents, a list of suggestions for observing Doctor's Day, invitations to Senior Day Tea, invitations to Fourth and Sixth District Meeting at Mammoth Cave, 98 letters concerning the Forand Bill.

It is with grateful appreciation that this report is written and to all who had a part in making this a wonderful Auxiliary year, may I say simply, thank you.

The Woman's Auxiliary to the Kentucky State Medical Association

Mrs. Jesse, Funk, President

Recommendations, Reference Committee No. 6

This Committee would like to take this opportunity to express its appreciation to those who have been so active in the Woman's Auxiliary of the Kentucky State Medical Association. They have indeed been

very busy this past year and have accomplished much in the right direction.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Mr. Speaker, I move the acceptance of Reference Committee No. 6 as a whole.

The motion was seconded and carried.

I wish to express my appreciation to each member of Reference Committee No. 6 for having taken such an active interest in the business of this Committee.

Reference Committee No. 6

N. Lewis Bosworth, M.D., Lexington, Chairman
Douglas H. Jenkins, M.D., Richmond, Vice Chairman
Harold Keen, M.D., Bowling Green
Billy J. Riddle, M.D., South Shore
W. H. Bryant, M.D., Glasgow

REFERENCE COMMITTEE NO. 7

Carl Cooper, M.D., Chairman
Reports of Miscellaneous Business

Report of the Committee on Physicians Placement Service

The Physicians Placement Service has been more active this year since the Director of Field Services spends a considerable portion of his time integrating this service with the Rural Scholarship Program. There have been no policy changes. The following are the activities that are being carried out:

1. *Working with the communities requesting physicians.*

When some lay person in a community makes a request, the secretary of the county medical society is contacted for approval before the community is added to the placement listing.

At the present time over 20 communities are on the listing. It is a known fact that a large number of these places cannot support a physician; therefore, a survey is being conducted and the Sears Roebuck Foundation is cooperating in this project.

If the survey shows the community cannot produce beyond a certain income level, then the community will be removed from the listing. If the survey shows this level can be attained, then the Foundation and Placement Service Committee will work with the community pointing out its responsibility in providng the necessary faclities to attract doctors. Several communties have been successful in securing physicians this year through our Placement Service.

2. *Physicians seeking locations.*

Numerous physicians have received personal cooperation and information this past year from Headquarters Office on areas in need of doctors and physicians that are wanting associates. The Placement Service has been instrumental on many occasions in placing available physicians.

Also, close contact has been kept with medical graduates as they do their internship as well as many doctors taking specialty training in regard to their locating.

From a survey made by our Placement Service of 92 U. of L. 1958 graduates, 46 of the 77 replies from interns indicated they would take specialty training and not do general practice. This being the trend, it makes it even more important that the Placement Service work more with qualifying general practitioners to keep them in Kentucky and those in other states to come to Kentucky.

The Physicians Placement Listing is being kept current by revising it at frequent intervals.

3. *Physicians wanting associates.*

Many doctors that have made their request to Headquarters Office for associates have been successful in securing one through our Placement Service.

Committee on Physicians Placement Service

Walter S. Coe, M.D., Louisville
Russell H. Davis, M.D., Pikeville
J. Thomas Giannini, M.D., Louisville
Daryl P. Harvey, M.D., Glasgow
Paul E. Holbrook, M.D., Ashland
Delmas M. Clardy, M.D., Hopkinsville, Chairman

Recommendations, Reference Committee No. 7

This report deals with the activities of the Placement Service working with the communities requesting physicians seeking locations and physicians wanting associates. At the present time over 20 communities are on the listing for physicians. A survey is being conducted and the Sears Roebuck Foundation is cooperating in this project. The Placement Service has been instrumental, on many occasions, in placing physicians in needy locations. Headquarters Office has been successful in securing associates for those physicians desiring assistants.

It is felt that the above committee is doing a fine job. Special thanks should be given to the Director of Field Services, Mr. Bobbie Grogan, for his investigation of the soundness of request for physicians in various communities. The survey by the Sears Roebuck Foundation of the needs of the community is of tremendous value in practical placement. It is recommended that the secretary of the KSMA write a letter of appreciation to the Sears Roebuck Foundation for their valuable assistance.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the Committee on Rural Health

The 1958 Committee on Rural Health has, in conjunction with the Rural Health Council of Kentucky, put on a program for the betterment of the health of our rural people. This program was planned and produced under the very able leadership of Dr. Wyatt Norvell, the preceding Chairman of the Rural Health Committee of Kentucky State Medical Association.

The present Committee made a survey of the registration at this conference. The geographical distribution as well as the attendance of the member organization of the Rural Health Council was very disappointing to the Committee, as it was found that one-third of the participating organizations had not one member present at this conference. The overwhelming majority of those attending were from Louisville, Frankfort and Lexington. These are not rural people and are not primarily the people we are trying to help to better health.

The conclusion that your Rural Health Committee reached was that we could reach more of the people that it was our mission to reach, if these conferences were held out in the state, away from our large urban centers. The solution to our problem, we felt, was to hold the conference in western Kentucky one year and eastern Kentucky the following year. The committee further was of the opinion that an intense publicity campaign should be undertaken in the immediate area, within one to two hours distance, so that our farm families could milk and do whatever chores should be done and drive to the conference, with a program planned so that they could drive back in time to do their chores in the evening. We further felt this was better from an economic point of view, since it would make it unnecessary for our rural people to spend the night and spend much needed dollars, and thus encourage attendance. The Rural Health Committee felt that rural health problems differed somewhat in these two areas and that the programs should be planned with this in mind. In addition, the expenses of this conference are underwritten by funds made available by the Kentucky State Medical As-

sociation, and every effort should be made to reach as many people as possible, with the careful expenditure of these funds.

The Rural Health Committee held three committee meetings on Dec. 3, 1958, April 9, 1959, and April 22, 1959. The Chairman met with the Rural Health Council on two occasions where the recommendations of the Rural Health Committee were received with enthusiasm, and it was decided to hold the conference at Bowling Green, November 5, and a joint program was planned for this conference. The theme of this meeting will be "Horizons in Rural Health."

We wish to invite all members of Kentucky State Medical Association and their wives to this conference, and we believe you will derive some new ideas for your own community, in horizons of rural health.

William Rudd, Executive Assistant, and Dr. Mitchell B. Denham, Chairman of the Rural Health Committee, attended the National Rural Health Conference at Wichita, Kansas, March 5, 6, 7. We obtained many very fine ideas to bring back to Kentucky.

This Committee wishes to thank Joe Sanford, William Rudd, Bobbie Grogan and Mrs. Ann Broadley for their work and help during the past year. They have been of great help to us and have cooperated in every respect.

Committee on Rural Health

Joseph R. Miller, M.D., Benton
Nathan Canter, M.D., Owensboro
Ralph D. Lynn, M.D., Elkton
Dixie E. Snider, M.D., Springfield
Everett N. Rush, M.D., Fern Creek
C. C. Howard, M.D., Glasgow
Wyatt Norvell, M.D., New Castle
Wilbur R. Houston, M.D., Erlanger
James S. Williams, M.D., Nicholasville
Donald L. Graves, M.D., Frenchburg
George P. Carter, M.D., Louisa
Carl Pigman, M.D., Whitesburg
Theodore R. Davies, M.D., Barbourville
Frank L. Duncan, M.D., Monticello, Vice Chairman
Mitchell B. Denham, M.D., Maysville, Chairman

Recommendations, Reference Committee No. 7

The 1958 Committee on Rural Health has, in conjunction with the Rural Health Council of Kentucky, put on a program for the betterment of the health of our rural people. A study of the registration at the conference disclosed that the attendance, insofar as the geographical distribution and member organizations of the Rural Health Council, was disappointing. The Rural Health Committee has prepared a series of conferences to be held out in the state to better reach the rural areas. This committee is to be commended for its plans to hold meetings in the different areas of the state, so that this can truly be a Rural Health Program. The next Rural Health Conference will be held at Bowling Green, Kentucky, November 5th, with the theme of the meeting being "Horizons in Rural Health." A program is attached to the back of Committee Report No. 25.

Mr. Speaker, I move the adoption of this section of the report.

The report was seconded and carried.

The KSMA Representatives on Joint Commission for Improvement of Patient Care

The Joint Commission for Improvement of Patient Care has met twice in the year 1958-1959. Various items were discussed but no definite action has as yet been determined. The discussions have always been interesting.

Joint Commission for Improvment of Patient Care

Winfrey P. Blackburn, M.D., Frankfort
Cooley L. Combs, M.D., Hazard
M. R. Walsh, M.D., Covington
Albert S. Warren, M.D., Lexington
Arthur T. Hurst, M.D., Louisville, Chairman

Recommendations, Reference Committee No. 7

This report states that there were two meetings in the year 1958 and 59, with various discussions, but no definite action. Your Reference Committee would appreciate more information concerning the items under discussion and proposed action. It is our feeling that this committee is a very important one and that there are several facets which we feel should be more thoroughly investigated and some courses of action charted.

It is recommended that more complete reports be submitted in the future.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the KSMA Representative to the State Practical Nurse Advisory Committee

As your KSMA representative to the State Practical Nurse Advisory Committee, the following report is made:

There were two meetings of the State Advisory Committee on Practical Nurse Education held—one on Thursday, December 18, 1958, at 10:30 a.m. in the Conference Room of the Department of Education in Frankfort. Your representative attended this meeting.

Miss Julia Beam, representing the Department of Education, gave a report on the programs currently operating in the state. She discussed accreditation of the various schools of Practical Nursing throughout the state and stated that pre-testing of the applicants for selection was required but no stereotype tests were used for all schools.

The next item on the agenda was a brief report concerning the financial status of the Practical Nursing Program in the state. Mr. Fred A. Martin, Director of Industrial and Distributive Education, Department of Education, Division of Vocational Education, State of Kentucky, stated that Kentucky had a total of $114,003 of Federal money available on dollar for dollar matching basis on this program for each year of the current biennium. However, the State of Kentucky had provided at this time an amount of $32,650 for matching purposes which meant that Kentucky this year is losing $81,353 of Federal money. He also stated that in order to continue the program of the Appalachian School of Practical Nursing in Lexington for the current year that it was necessary to solicit an amount of $9,368.50 as a donation to the Appalachian Fund to be used for matching purposes. It was unanimously felt that the educational program taking place was a most worthwhile one and that the direct responsibility of the State should not be dependent upon any other agency or groups of funds for its operation.

Doctor Raymond B. Drukker, representing the Appalachian Fund, stated that the Appalachian Fund had been most happy for the State of Kentucky to take over the financial state of operation for this school. He also stated that in this particular instance, where the State had not provided adequate matching funds, that the Appalachian Fund was willing to furnish the funds necessary for the current fiscal year but then was expecting the State to assume this obligation henceforth.

A Committee was appointed to study the financial situation and take whatever action deemed necessary

to secure the funds to continue the operation of the Appalachian Program.

It was felt by the members present that the program of Practical Nursing in the State of Kentucky should be publicized both from the standpoint of obtaining prospective students and also to acquaint the general public with what is being done along these lines.

A motion was made, seconded and carried that the State Advisory Committee on Nurse Education should meet quarterly.

The meeting was adjourned at 2:15 p.m.

The next meeting was held Thursday, May 21, 1959, in Frankfort, and your representative could not attend this meeting because of a conflicting meeting of the Associate Committee on Nurse Training of the KSMA which was attended by your representative.

KSMA Representative to the State Advisory Committee on Practical Nurse Education
N. L. Bosworth, M.D., Lexington

Recommendations, Reference Committee No. 7

This report deals with the training programs for Practical Nursing throughout the state. Also, the financial status of the Practical Nursing Program in the state. It was stated that Kentucky had a total of $114,003 of Federal money available on dollar for dollar matching basis for practical nurses' training. However, the state of Kentucky had provided an amount of $32,650 for matching purposes, which meant that Kentucky this year is losing $81,353.00 of Federal money. In order to continue the program of the Appalachian School of Practical Nursing in Lexington for the current year it was necessary to solicit an amount of $9,368.50 as a donation. Your Reference Committee commends the representative for such an informative report on a very important program. We feel that the state of Kentucky should take advantage of the matching Federal funds to train more practical nurses. It is recommended that this report be studied by the Legislative Committee and that the various state legislators be advised as to the importance of this program.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the KSMA Representatives to The State Tuberculosis Coordinating Council

At the present time the Coordinating Council has before it for consideration two problems:

(1) The method of the future operation of Waverly Hills T. B. Sanitarium.

(2) A survey of the type of patients on the Board of Health's census of active tuberculosis patients throughout the state.

KSMA Representatives to the State Tuberculosis Coordinating Council
Joseph H. Humpert, M.D., S. Ft. Mitchell
Richard E. Mardis, M.D., Louisville

Recommendations, Reference Committee No. 7

This report states that there are two problems that are under consideration by the Coordinating Council.

1) The method of the future operation of the Waverly Hills Tuberculosis Sanitorium, and

2) A survey of the type of patients on the Board of Health Census of active tuberculosis patients throughout the state.

Your Reference Committee feels that no action or recommendation is necessary on this report.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Report of the Rural Kentucky Medical Scholarship Fund

The Rural Kentucky Medical Scholarship Committee has been very active since the last session of the House of Delegates meeting. In addition to the annual meeting of the Scholarship Board of Trustees, the Executive Committee of the Board and the Scholarship Postgraduate Committee have held two meetings each.

At the annual meeting first-year loans were approved for 20 applicants. Of this number 15 will be freshmen and 5 sophomores. Renewal approval of second, third and fourth loans was given to 22 sophomores, 13 juniors, and 15 seniors. Nine students will be in school that have been granted previous loans that did not request to have them renewed at the time this report was prepared.

From the above-mentioned three groups a total of 79 students will be attending medical schools in 1959-60 that are receiving or have received Rural Kentucky Medical Scholarship loans.

In projecting scholarship recipients, those now taking internship and those in medical schools, to the date they will be eligible for practice they are as follows: 7 in July 1960, 17 in July 1961, 17 in July 1962, 31 in July 1963 and 16 in July 1964.

A total of 189 students have received loans since the program started in 1946. Of this number 55 are now practicing in rural areas of Kentucky. Seven others fulfilled their obligation by practicing in rural areas before relocating. Eight are in military service. Eleven dropped out of school because of poor grades, financial reasons, etc. Some have been granted permission to take specialty training then return to qualifying areas. Only two recipients have failed to live up to at least part of their obligation by not practicing in a rural area.

When the Board of Trustees reviewed the ten most critical counties in need of doctors, it was decided that Owsley County should replace Cumberland County since a recipient was located in Cumberland. The counties now on the critical list are Jackson, McGoffin, Martin, Elliott, Knott, Breathitt, Leslie, Knox, Powell, and Owsley.

The Board of Trustees is most appreciative and grateful to the Governor and to the Senators and House of Representatives for their support of the scholarship program in the amount of $100,000 for the last four years. This amount has been received and is now being used in the form of loans to worthy medical students.

We especially want to thank the Council for the fine work Mr. Grogan and his staff have done for this program. Mr. Grogan's field work has been invaluable.

Rural Kentucky Medical Scholarship Fund
C. C. Howard, M.D., Glasgow
Chairman, Board of Trustees

Recommendations, Reference Committee No. 7

This report states that at the annual meeting first-year loans were approved for 20 applicants, consisting of 15 freshmen and 5 sophomores. Renewal approval of second, third and fourth loans was given to 22 sophomores, 13 juniors and 15 seniors. From these groups, a total of 79 students will be attending medical schools in 1959 and 60 who are receiving, or have received, rural Kentucky Medical Scholarship Funds. A total of 189 students have received loans since the program started in 1946. 55 are now practicing in rural areas; 7 others fullfilled their obligation before re-locating; 8 are in Military Service; 11 dropped from school; some have been granted permission to take specialty training; and only two recipients failed to live up to at least part of their obligation.

This report expresses its appreciation to the Governor and to the Senators and House of Representatives for their support of the Scholarship Program in the

(Continued on Page 1564)



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Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

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(Continued from Page 1562)

amount of $100,000 for the last four years. This report also mentions the thanks to the Council and to Mr. Bobbie Grogan and his staff for their work in this program. Your Reference Committee would like to recommend that all members of the House of Delegates study this report so that they may know how well this program is working. We would like to commend Dr. C. C. Howard, the Board of Trustees, and Mr. Bobbie Grogan for their good work.

Mr. Speaker, I move the adoption of this section of the report.

The motion was seconded and carried.

Mr. Speaker, I move the adoption of this report as a whole.

The motion was seconded and carried.

As chairman of Reference Committee No. 7, I would like to express my thanks to each member of this committee, as well as to Dr. J. M. Stevenson, Brooksville, and to Dr. Norman Adair, Covington, for their assistance.

Reference Committee No. 7

Carl Cooper, Bedford, Chairman
L. Douglas Atherton, Louisville, Vice Chairman
Maurice Kaufmann, Lexington
Harry Denham, Maysville
Arthur Cooper, Somerset

Unfinished Business

A motion was duly made and seconded that the House of Delegates congratulate the staff of KSMA for furnishing mimeographed copies of the Reference Committee reports.

Election of Officers

At this time a motion was made, seconded and carried that the nominations to fill the vacant offices for the coming year be closed, and the following nominees were presented:

President-Elect—Paul B. Hall, M.D., Paintsville; Richard Elliott, M.D., Lexington

Doctor Elliott was elected President-Elect, and the following by full vote of the House:

Vice Presidents:

Central—David Cox, M.D., Louisville
Eastern—W. D. Preston, M.D., Lexington
Western—Rex Hayes, M.D., Glasgow

Delegates to AMA—W. Vinson Pierce, M.D., Covington

Alternate Delegate to AMA—Vernon Pace, M.D., Paducah

Election of Councilors

The delegates from the counties in the districts which were to elect councilors and who had held individual meetings after the first session of the House, presented their nominations and the following were elected by the vote of the full House of Delegates:

First District—Hugh L. Houston, M.D., Murray
Third District—Ralph D. Lynn, M.D., Elkton
Fourth District—Dixie E. Snider, M.D., Springfield
Twelfth District—Tom O. Meredith, M.D., Harrodsburg
Fourteenth District—William C. Hambley, M.D., Pikeville

Nominations for Board of Directors, Kentucky Physicians Mutual, Inc.

The following list of nominees was submitted for vacancies on the Board of Directors of the Kentucky Physicians Mutual, Inc.:

Darrel Peterson, M.D., Louisville
William Buschmeyer, M.D., Louisville

Motions were made, seconded and carried that the above names be submitted to the Board of Directors of the Kentucky Physicians Mutual, Inc.

Election of 1960 Nominating Committee

The Nominating Committee to serve at the 1960 Annual Meeting was duly elected as follows:

Wendell V. Lyon, M.D., Ashland
James W. Archer, M.D., Paintsville
Daniel E. Mahaffey, M.D., Louisville
Gaithel L. Simpson, M.D., Greenville
Frank Hayes Threlkel, M.D., Owensboro

At this point, Irvin Abell, M.D., Louisville, was installed in office with administration of the Oath of Office by the Chairman of the Council, and the new President's first official act was that of presenting the past president's key to the retiring president, Doctor Robertson.

Doctor Sparks then told the House of Delegates that since this would be the last meeting over which he would preside as Speaker of the House, he wished to express his deep appreciation for the cooperation and help the members had given him. He said that serving in the capacity of Speaker of the House had been one of the ". . .grandest experiences one could have, and I bow out with the greatest humility and sadness, but with a lot of fine memories and a lot of wonderful friends. I thank you all so much for your help." (Applause.)

Wyatt Norvell, M.D., New Castle, asked for the floor at this time and said, "Clyde Sparks, the House of Delegates wishes to thank you for your fairness and the splendid way in which you have presided over this body for the past three years. We all deeply appreciate the contribution you have made."

The Vice Speaker, Doctor Pedigo, thanked the members of the House for their kind attention and courtesy at this session and stated that it had been both a pleasure and an education for him to have served in the capacity of Vice Speaker of the House for the past three years.

There being no further business, a motion was made, seconded and carried that the 1959 meeting of the House of Delegates adjourn at 10:10 p.m.

House-Appointed Committees Named by Dr. Overstreet

Committees appointed by the House of Delegates of KSMA for 1959-60 have been announced by Sam A. Overstreet, M.D., Louisville, Speaker of the House. They are:

Awards Committee

William H. Bizot, M.D., Chairman, Louisville
Theodore Davis, M.D., Barbourville
Horace Harrison, M.D., Owensboro
W. M. Savage, M.D., Maysville
Douglas Scott, M.D., Lexington

Committee to Study the Constitution and Bylaws

Cooley L. Combs, M.D., Chairman, Hazard
Robert S. Dyer, M.D., Louisville
Barton L. Ramsey, M.D., Somerset
Richard J. Rust, M.D., Newport
George H. Widener, M.D., Paducah

ORGANIZATION SECTION

ACS Announces Program For Louisville Meeting Jan. 21-23

The tentative program for the three-day Sectional Meeting of the American College of Surgeons, to be held at the Brown Hotel in Louisville, January 21-23, has been announced by Rudolf J. Noer, M.D., Louisville, chairman of the advisory committee on local arrangements.

The meeting, the first in the 1960 series of six scheduled by ACS throughout the country, will be the first College session in Louisville since 1950.

In addition to the general surgery program, special sessions have been arranged for ophthalmotologists, otolaryngologists and medical directors of approved cancer programs.

The general surgery program follows:

Thursday Morning, Jan. 21

Rudolf J. Noer, M.D., Presiding

Surgery in the Patient With Heart Disease: Some Aspects in Pre-and-Postoperative Management—Edmund D. Pellegrino, M.D., Lexington, Ky.

Selection of Therapy for Peripheral Arterial Disease—W. Andrew Dale, M.D., Nashville, Tenn.

Management of Acute Arterial Injuries—W. Sterling Edwards, M.D., Birmingham.

Practical Techniques in Burn Care—Curtis P. Artz, M.D., Jackson, Tenn.

Role of Surgery in Thyroid Disease—Richard B. Cattell, M.D., Boston, Mass.

Pitfalls in Surgery of Bilary Tract—Francis M. Massie, M.D., Lexington, Ky.

Indications for Surgery in Gastric Ulcer—Edward R. Woodward, M.D., Gainesville, Fla.

Thursday Afternoon, Jan. 21

Ernest C. Strode, M.D., Lexington, Presiding

Use of Cytology in Surgery—Cyrus C. Erickson, M.D., Memphis, Tenn., moderator; William Christophersen, M.D., Louisville, and Justin J. Cordonnier, M.D., St. Louis, collaborators.

Friday Morning, Jan. 22

Coleman C. Johnston, M.D., Lexington, Presiding

Hazard of Air Embolism—Henry G. Hollenberg, M.D., Little Rock, Ark.

Everyday Low Back Problems—George K. Carpenter, M.D., Nashville.

Urinary Diversion—Eugene M. Bricker, M.D., St. Louis.

The Ovarian Cyst: Diagnosis and Treatment—John C. Burch, M.D., Nashville.

Symposium on Cancer:

Irradiation vs. Surgery in Cancer of the Cervix—Ralph A. Reis, M.D., Chicago, and Condict Moore, M.D., Louisville.

Choice of Ablative Surgery for Recurrent Breast Cancer—George B. Sanders, M.D., Louisville; John C. Burch, M.D., Nashville; Henry G. Hollenberg, M.D., Little Rock.

Hormonal Therapy vs. Radical Excision in Cancer of the Prostate—Justin J. Cordonnier, M.D., St. Louis, and Robert Lich, Jr., M.D., Louisville.

Friday Afternoon, Jan. 22

Robert W. Robertson, M.D., Paducah, Presiding

Posterative Infections and Their Significance—William A. Altemeier, M.D., Cincinnati.

Significance and Treatment of Malnutrition in Surgical Patients—Warren H. Cole, M.D., Chicago.

Urologic Complications—Edgar Burns, M.D., New Orleans.

Causes and Treatment of Hypotension in the Immediate Postoperative Period—Sam. S. Clark, M.D., Louisville.

The Acute Abdomen — Panel Discussion: R. Arnold Griswold, M.D., Louisville, moderator; Isadore Cohn, Jr., M.D., New Orleans; Eugene H. Countiss, M.D., New Orleans; James C. Drye, M.D., Louisville and James M. Mason III, M.D., Birmingham, Collaborators.

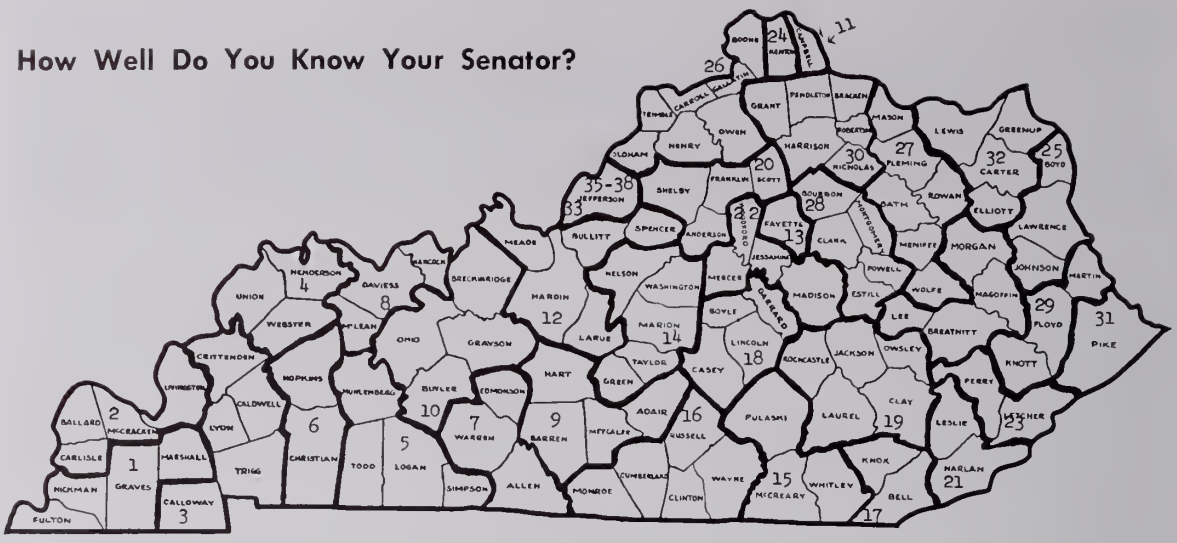
Specialty Sessions

A two-day ophthalmic surgery program is being arranged by C. Dwight Townes, M.D., Louisville, for presentation at the Brown Hotel on January 22 and at Louisville General Hospital on January 23. Speakers will include William H. Havener, M.D., Columbus; Harold G. Scheie, M.D., Philadelphia; Banks Anderson, M.D., Durham; Roscoe J. Kennedy, M.D., Cleveland, and Charles T. Moran, M.D., Roderick Macdonald, Jr., M.D., and C. Dwight Townes, M.D., all of Louisville. Kurt Ackermann, M.D., Louisville, will preside at the Saturday morning session.

A Cancer Program Workshop will be conducted on January 22 at General Hospital by James C. Drye, M.D., Louisville.

A special two-day session for otolaryngologists has been planned by William C. Wolfe, M.D., Louisville, to be held at the Brown Hotel on January 22 and at General Hospital on January 23. Participants on the Friday program will include Peter M. Pastore, M.D., Richmond; Arthur L. Juers, M.D., Louisville; A. C. Poweleit, M.D., Covington; Robert Boswell, M.D., Dayton.

Staff members of General Hospital will conduct a clinic on the closing day of the conference. Participating will be Harold Baker, M.D.; Layman A. Gray, M.D., Douglas M. Haynes, M.D.; Robert Long, M.D.; Robert Monroe, M.D., and Silas H. Starr, M.D.



Number denotes Kentucky Senatorial District and indicates county in which Senator lives.

Kentucky's State Legislators For 1960 Are Listed

If new laws are passed or if present laws are amended during the 1960 Session of the Kentucky General Assembly, the senators and representatives listed below will **make the changes.** These legislators are anxious to represent the people in their areas if they know the wishes of their citizenry.

In order to assist members of KSMA to know more about their legislators during the 1960 session of the Kentucky General Assembly, the Journal is printing a list of their names, addresses, and districts, with maps showing the counties they serve.

Kentucky General Assembly 1960 Members of Senate

District	Home County	Senators
1	Graves	George Brand-D, Mayfield
2	McCracken	Strother Melton-D, Paducah
3	Calloway	George E. Overbey-D, Murray
4	Henderson	J. Murray Blue-D, Henderson
5	Logan	Everett White-D, Russellville
6	Christian	Frank H. Bassett, Jr.-D, Hopkinsville
7	Warren	Rex A. Logan-D, Smiths Grove
8	Daviess	E. W. Richmond-D, Owensboro
9	Barren	Richard L. Garnett-D, Glasgow
10	Butler	Ulysses G. Byers-R, Welchs Creek
11	Campbell	Lambert Hehl, Jr.-D, Fort Thomas
12	Hardin	Clyde S. Howard-D, Elizabethtown
13	Fayette	Shelby C. Kinkead-D, Lexington
14	Marion	B. E. Hickerson-D, Lebanon
15	McCreary	O. O. Duncan-R, Whitley City
16	Russell	Sam Hubbard-R, Russell Springs
17	Bell	Durham W. Howard-R, Pineville
18	Lincoln	Cabell D. Francis-D, Stanford
19	Clay	Fred F. Bishop-R, Teges
20	Scott	James R. Hamilton-D, Georgetown
21	Harlan	H. Nick Johnson-R, Harlan
22	Woodford	Paul Jackson-D, Versailles
23	Letcher	Archie Craft-D, Whitesburg
24	Kenton	James C. Ware-D, Covington
25	Boyd	George D. Conley-D, Ashland
26	Gallatin	Alvin Kidwell-D, Sparta
27	Fleming	Ed J. Kelly-D, Flemingsburg
28	Bourbon	Cassius M. Clay-D, Paris (deceased)
29	Floyd	Burnis T. Martin-D, Prestonsburg
30	Nicholas	H. Stanley Blake-D, Carlisle
31	Pike	Tom Raney-D, Pikeville
32	Carter	Mrs. J. Harry Davis-R, Grayson
33	Jefferson	Bernard J. Bonn-D, Louisville
34	Breathitt	Charles H. Davis-D, Jackson
35	Jefferson	Martin J. Duffy-D, Louisville
36	Jefferson	Scott Miller, Jr.-R, Louisville
37	Jefferson	Charles W. A. McCann-D, Louisville
38	Jefferson	Gates F. Young-D, Louisville

Kentucky General Assembly 1960 Representatives

District	Home County	Representatives
1	Fulton	Joe W. Treas-D, Fulton
2	Carlisle	Roy C. Davis-D, Bardwell
3	Graves	Lon Carter Barton-D, Mayfield
4	McCracken	James R. Miles-D, Paducah
5	McCracken	Fred Morgan-D, Paducah
6	Marshall	O. L. Chumbler-D, Benton

District	Home County	Representatives
7	Calloway	W. Otis Lovins-D, Murray
8	Caldwell	Virgil Smith-D, Princeton
9	Christian	William F. Edmunds-D, Hopkinsville
10	Hopkins	Frederick E. Nichols-D, Madisonville
11	Livingston	George F. Harris-D, Salem
12	Union	Will Tom Wathen-D, Morganfield
13	McLean	Richard Hopkins-D, Calhoun
14	Henderson	Henry C. Neel-D, Henderson
15	Daviess	Pat Tanner-D, Owensboro
16	Daviess	R. Douglas Ford-D, Owensboro
17	Muhlenberg	James P. Hahn-D, Greenville
18	Ohio	Wayland Render-R, Centertown
19	Todd	H. A. Hampton-D, Trenton
20	Logan	Paul E. Young-D, Olmstead
21	Simpson	Thomas M. Brizendine-D, Franklin
22	Warren	A. E. Tucker-D, Bowling Green
23	Butler	Glen T. White-R, Morgantown
24	Grayson	Robert Spurrier-R, Falls of Rough
25	Hardin	Leonard W. Cole-D, Vine Grove
26	Breckinridge	Walter R. Moorman-D, Hardinsburg
27	Barren	George J. Ellis, Jr.-D, Glasgow
28	Monroe	Earl Carter-R, Tompkinsville
29	Green	Ben E. Burress-R, Greensburg
30	Taylor	Robert Henry Cowherd-D, Campbellsville
31	Hart	C. E. Dowell-D, Horse Cave
32	Nelson	Sam Houtchens-D, Bloomfield
33	Bullitt	J. D. Buckman, Jr.-D, Shepherdsville
34	Jefferson	Marlow Webster Cook-R, Louisville
35	Jefferson	Thomas L. Ray-D, Louisville
36	Jefferson	William J. Crecelius-D, Louisville
37	Jefferson	Lawrence Osting-D, Louisville
38	Jefferson	Clarence R. Miller-D, Louisville
39	Jefferson	John W. Farmer-D, Louisville
40	Jefferson	Edwin A. Rausch, Sr.-D, Louisville
41	Jefferson	Charles E. Baumgardner, Sr.-D, Louisville
42	Jefferson	William H. Childress-D, Louisville
43	Jefferson	Albert Steiger, Jr.-D, Louisville
44	Jefferson	Matthew B. Quinn, Jr.-D, Louisville
45	Mercer	Eulyn L. Dean-D, Harrodsburg
46	Boyle	Frank Zeke Dexter-D, Danville
47	Madison	Jerry W. Parrish-D, Richmond
48	Woodford	James T. Alexander-D, Versailles
49	Fayette	Ted R. Osborn-D, Lexington
50	Fayette	R. P. (Dick) Moloney-D, Lexington
51	Franklin	Ralph Bates-D, Frankfort
52	Shelby	Luther F. Morgan-D, Shelbyville
53	Trimble	Harry W. Wood-D, Milton
54	Boone	Dan J. Roberts-D, Walton
55	Owen	Albert C. Smith-D, Monterey
56	Scott	W. K. "Bill" Henry-D, Georgetown
57	Henry	Louis T. Peniston-D, New Castle
58	Kenton	Charles L. Summe-D, Covington
59	Kenton	Vernor O. Cottengim-D, Covington
60	Kenton	John J. Isler-D, Covington
61	Kenton	Thomas P. Fitzpatrick-D, Covington
62	Campbell	Eugene Ostertag-D, Cold Spring
63	Campbell	James E. Murphy-D, Newport
64	Bracken	Finnell L. Fields-D, Brooksville

How Close Are You to Your Representative?



Number denotes Kentucky House of Representative District and indicates county in which Representative lives.

District	Home County	Representatives
65	Mason	Mitchell B. Denham, M.D.,-D, Maysville
66	Fleming	Herbert F. Fern-D, Ewing
67	Bourbon	Brooks Hinkle-D, Paris
68	Clark	William W. Haley-D, Winchester
69	Menifee	Kenneth Nolan-D, Rothwell
70	Rowan	Melvin Hardin-D, Morehead
71	Lewis	Hobart Rayburn-R, Vanceburg
72	Greenup	James W. Lyon-D, Raceland
73	Carter	Roger E. Qualls-R, Olive Hill
74	Knott	B. Bill Cornett-D, Hindman
75	Morgan	H. Roland Stacy-D, West Liberty
76	Lee	Russell Reynolds-D, Beattyville
77	Powell	Chester A. Stidham-D, Stanton
78	Jackson	Ed E. Hays-R, Gray Hawk
79	Rockcastle	Charles C. Carter-R, Mt. Vernon
80	Lincoln	Thomas Jefferson Hill, III-D, Stanford
81	Casey	R. S. Griffin-R, Liberty
82	Clinton	Clete L. Garner-R, Highway
83	Wayne	Wendell Hardwick-R, Betsey
84	Pulaski	Leonard Hislope-R, Somerset
85	Whitley	John Faulkner, Jr.-R, Williamsburg
86	Laurel	Paul W. Cornett-R, Mershons
87	Knox	Buford Clark-R, Barbourville
88	Bell	Mason Slusher-D, Beverly
89	Harlan	Lawrence Lankford-D, Cawood
90	Harlan	Robert Hall-R, Cumberland
91	Clay	John E. White-R, Manchester
92	Letcher	Harry M. Caudill-D, Whitesburg
93	Perry	J. D. Smith-D, Dwarf
94	Pike	T. T. Colley-D, Virgie
95	Pike	Gether Irick-D, Stone
96	Floyd	Clarence "Ollie" Robinson, Jr.-D, Prestonsburg
97	Floyd	Ben Martin-D, Drift
98	Johnson	Sterling Castle-R, Nippa
99	Lawrence	Russell Dobyns-D, Louisa
100	Boyd	Harry King Lowman-D, Ashland

Postgraduate Medical Office Planned at U. of L.

Plans for opening a postgraduate medical office on the grounds of the University of Louisville were discussed by the KSMA Associate Committee on Postgraduate Education at its meeting on November 19.

The office, to occupy space provided by the university, will be opened as soon as the necessary personnel can be hired, Walter S. Coe, M.D., chairman of the committee, announced.

When the office becomes operative, all physicians, specialty groups and medical schools are urged to contact the staff for assistance in planning postgraduate courses. It is hoped the office will become a clearing house for postgraduate activity in Kentucky.

Another goal of the committee is to set up postgraduate programs three years in advance in Kentucky. It is felt this will eliminate conflicts in dates and programs and at the same time assist those holding the courses in deciding what topics to cover.

As an added service to KSMA members, postgraduate courses being opened by medical schools in seven adjoining states will be listed in the KSMA Journal beginning in 1960. This listing will be quarterly, in conjunction with that of the postgraduate courses offered in Kentucky.

Dr. McCarty Named First V-P. By Southern Medical

A. Clayton McCarty, M.D., Louisville, was named first vice-president of the Southern Medical Association at the organization's 53rd annual meeting in Atlanta, November 16-19. The election automatically puts him in line for the presidency of Southern Medical in 1961.

Doctor McCarty was formerly a Councilor from Kentucky on the SMA Council and served as its chairman. J. Duffy Hancock, M.D., Louisville, is the current Councilor from Kentucky.

The late Elmer Henderson, M.D., Louisville, was the last Kentuckian to serve as president of Southern Medical. He held the office in the late 40's.

Doctor McCarty is chairman of the Medical Advisory Committee to Selective Service in Kentucky. He is new vice-president of the American Geriatrics Society and chairman of the KSMA Associate Committee on Problems of the Aged. He formerly served KSMA as a vice-president and is a past president of the Jefferson County Medical Society.

Carroll L. Witten, M.D., Louisville, was chosen chairman of the section on general practice of the Southern Medical Association. He formerly served as secretary of the section.

The Journal hopes to carry a list of all Kentuckians who attended the SMA meeting in the January issue.

Social Security Taxes Up Jan. 1

Effective January 1, 1960, KSMA members, along with other employers, will be required by law to deduct more money from pay checks for social security taxes—and at the same time to match this increase with their own funds.

The tax rate on both employers and employees will be increased from the present 2 1/2% to 3%, involving a maximum deduction of $144 next year as compared to the maximum of $120 this year. These changes are effective for the first payday of 1960, regardless of the fact that part or all of the services for which the pay is given may be performed in 1959.

Mid-South Assembly Feb. 9-12

The Mid-South Postgraduate Medical Assembly will be held February 9-12, 1960, at the Peabody Hotel in Memphis, Tenn., according to announcement by William G. Stephenson, M.D., Chattanooga, president.



FIVE KEY FIGURES in spearheading the drive for better health in rural Kentucky, who attended the seventh annual Rural Health Conference in Bowling Green November 5, were, left to right, John Koon, Louisville, executive secretary of the Kentucky Farm Bureau and a member of the Rural Health Council; Walter L. O'Nan, M.D., Henderson, former Rural Health Council chairman; E. M. Josey, secretary of the Kentucky Pharmaceutical Association and member of the Rural Health Council; C. C. Howard, M.D., Glasgow, member of the Rural Health Council, and Miss Sara Stice, Louisville, State Department of Health, member of the Rural Health Council.

154 At Rural Health Conference In Bowling Green

The seventh annual Kentucky Rural Health Conference, held November 5 at the Olde Fort in Bowling Green, drew an attendance of 154, with 25 counties represented.

This was the first conference held outside of Louisville, and the success of the meeting prompted a proposal to hold the 1960 session in Eastern Kentucky.

"It looks as if the idea of moving the conference to the rural people has real merit," said Mitchell B. Denham, M.D., Maysville, chairman of the Kentucky Rural Health Council, which sponsors the conferences.

Doctor Denham was re-elected chairman for his second one-year term. Miss Wilma Vandiver of the University of Kentucky Extension Department was named vice chairman, and Mrs. T. E. Roberts, Louisville, of the Kentucky Farm Bureau Federation, was re-elected secretary.



NEW OFFICERS of the Kentucky Rural Health Council formulate plans for next year's conference. Chairman Mitchell B. Denham, M.D., Maysville, talks with the vice chairman, Miss Wilma Vandiver, Lexington, University of Kentucky Extension Department, center, and the secretary, Mrs. T. E. Roberts, Louisville, Kentucky Farm Bureau.

ACS Renames Kentucky Governors

R. Arnold Griswold, M.D., Louisville, and Coleman C. Johnston, M.D., Lexington, were re-elected to three-year terms as Governor for Kentucky of the American College of Surgeons at a meeting in Atlantic City early in November.

AAMC Re-elects Dr. Kinsman

J. Murray Kinsman, M.D., dean of the University of Louisville School of Medicine, was re-elected treasurer of the Association of American Medical Colleges at the group's annual meeting in Chicago, November 2-4. He was named for a three-year term.



THE CONVERSATION seems to be on milk at a break during the conference. Milk was furnished by the Kentucky Dairy Association. Three participants in the program were, left to right, Gaithel Simpson, M.D., Greenville; Burl St. Clair, Falls of Rough, president of the Kentucky Farm Bureau, and T. R. Bryant, Lexington, U. K. Extension Service.

PG Offerings for First Quarter Of 1960 Announced

Postgraduate medical opportunities available to Kentuckians for the first quarter of 1960 have been announced by Walter S. Coe, M.D., chairman of the KSMA Committee on Postgraduate Medical Education. For the first time, the committee is including meetings out of the state, within reach of Kentucky physicians. In this new service, postgraduate opportunities from seven adjoining states will be included in the 1960 listings.

The list follows:

January

21-23 American College of Surgeons, Sectional Meeting; Brown Hotel, Louisville; 8:45 A.M., CST.

21 KAGP, Northern Kentucky Seminar; Sheraton Gibson Hotel, Cincinnati.

February

24-26 Postgraduate Course in Obstetrics and Gynecology; University of Tennessee, Memphis.

March

9-10 Annual Symposium on Cardiovascular Diseases; 9 A. M., Brown Hotel, Louisville.

17-18 Postgraduate Course in Anesthesia for the General Practitioner; University of Tennessee, Memphis.

30-April 1 Postgraduate Course in Recent Advances in Pediatrics; University of Tennessee, Memphis.

Kentucky Flying Physicians Plan Next Fly-In Feb. 6-7

Kentucky's Flying Physicians are planning their second state-wide fly-in at Kentucky Lake the weekend of February 6-7, according to Norman K. Cohen, M.D., Louisville, corresponding secretary and editor of the group. Their first gathering was held at Owensboro on October 18.

A program of scientific sessions and free instrument-flight instruction is being arranged by Max P. Jones, M.D., Louisville, program chairman. The instrument-flight instructors are Marvin Bowers, Jr., M.D., Louisville, and Francis X. Sommer, M.D., Corbin.

Social activities will include a dinner Saturday night and a breakfast Sunday morning.

The Kentucky section of Flying Physicians, numbering some 50 members, is a part of the national organization which was founded in Chicago in May, 1955, and held its first meeting in Atlantic City the following month. Members are available to fly to stricken areas for disaster-relief work.

A number of the physicians fly their own planes. Aubrey L. Embry, M.D., Millwood, and Richard E. Davis, M.D., Central City, have their own planes and landing strips as well. James R. Hendon, M.D., and James E. Bryan, M.D., of Louisville, own a plane jointly, as do two other Louisvillians, Max P. Jones, M.D., and Oscar J. Hayes, M.D. Other plane-owners include James H. Callis, M.D., Owensboro, Western co-chairman of the group, and George M. Gumbert, M.D., Lexington.

KSMA Members Address Regional Conference On Aging

Three members of the Kentucky State Medical Association were on the program of the AMA's third Regional Conference on Aging, held in Cleveland October 28-29, in cooperation with the state medical societies of Indiana, Kentucky, Michigan, Ohio and Pennsylvania.

W. Vinson Pierce, M.D., Covington, KSMA delegate to the AMA and a member of the Committee on Insurance and Pre-Payment Plans, AMA Council on Medical Service, spoke on "Health Insurance." A. Clayton McCarty, M.D., Louisville, chairman of the KSMA Committee on Problems of the Aged, described what Kentucky is doing in this field. Irvin Abell, Jr., M.D., Louisville, president of KSMA, gave a summation of the subject, "What Our States Are Doing."

Several prominent speakers stressed the point that aging is a community responsibility and not one of Federal legislative force. They emphasized the importance of making plans early in life for a gradual retirement, of participating in church and civic affairs, and of growing old gracefully.

The approximately 375 persons who attended the conference heard Doctor Abell in summation say, "Let's return home and all medical groups join hands on a community level to prepare a better way of life for our senior citizens."

The Kentucky delegation, in addition to the three speakers, included Edwin Cameron, M.D., Louisville, State Department of Health; Mrs. Goldie Waskey, LPN, Russell, president of the Kentucky Licensed Practical Nurses Association; Msgr. Charles A. Towell, Covington, and Bill Rudd, KSMA executive assistant.

Sixth Councilor District Elects Dr. Wood of Auburn

New officers of the Sixth Councilor District, elected at the fall meeting in Russellville on November 10, have been announced by John P. Glenn, M.D., Russellville, Councilor of the District. Charles A. Wood, M.D., Auburn, was elected president; Richard F. Grise, M.D., Bowling Green, was named vice-president, and Walter H. Griffing, M.D., Bowling Green, was re-elected secretary.

Speaker for the meeting was James L. Doenges, M.D., Anderson, Ind. In answer to the question of socialized medicine, he pointed out that the physician is responsible to the patient and the patient to the physician without intermediaries, a relationship that can be brought about in the doctor's office.

Thirty-three members and guests attended the meeting.

Council-Appointed Committees For 1959-60 Announced

Committees appointed by the KSMA Council to serve during the 1959-60 Association year have been announced by the Chairman of the Council, Carlisle Morse, M.D., Louisville. They are as follows:

Committee on Medical Education and Economics

Gaithel L. Simpson, M.D., Chairman, Greenville
John Quertermous, M.D., Murray
O. Leon Higdon, M.D., Paducah
John Dickinson, M.D., Glasgow
Claude C. Waldrop, M.D., Williamstown

***Associate Committee on Insurance**

John Dickinson, M.D., Chairman, Glasgow
Robert E. Reichert, M.D., Covington
J. Auldin Bishop, M.D., Jeffersontown
Ernest C. Strode, M.D., Lexington
William Morgan, Jr., M.D., Paris

***Associate Committee to the University of Louisville School of Medicine**

John Quertermous, M.D., Chairman, Murray
Delou P. Hall, M.D., Louisville
John G. Archer, M.D., Prestonsburg
Mitchell B. Denham, M.D., Maysville
Tom Threlkeld, M.D., Russellville

***Associate Committee for Contribution to the American Medical Education Foundation**

Claude C. Waldrop, M.D., Chairman, Williamstown
James W. Fuller, M.D., Mayfield
Paul B. Hall, M.D., Paintsville
Bob McClendon, M.D., Louisville
Chester R. Lewis, M.D., Georgetown

***Associate Committee on Federal Medical Services**

O. Leon Higdon, M.D., Chairman, Paducah
Daniel L. Bower, M.D., Williamsburg
Morris M. Garrett, M.D., Covington
Coleman C. Johnston, M.D., Lexington
Carroll L. Witten, M.D., Louisville

Medico-Legal Administrator

John D. Gordinier, M.D., Louisville

Advisory Committee to the Editor

James Hix, M.D., Chairman, Owensboro
Bob Hoffman, M.D., Fort Mitchell
Francis Massie, M.D., Lexington

Committee on Public Information and Service

N. Lewis Bosworth, M.D., Chairman, Lexington
Jess T. Funk, M.D., Bowling Green
Carl Cooper, Jr., M.D., Bedford
Donald K. Dudderar, M.D., Newport
Robert S. Dyer, M.D., Louisville

Committee on Physicians Placement Service

Paul E. Holbrook, M.D., Chairman, Ashland
Walter S. Coe, M.D., Louisville
Delmas M. Clardy, M.D., Hopkinsville
Russell H. Davis, M.D., Pikeville
James C. Salato, M.D., Columbia
Si Past, M.D., Olive Hill

**These Associate Committees report to the Committee on Medical Education and Economics and not to the House of Delegates.*

Committee on Legislation

Wyatt Norvell, M.D., Chairman for State Affairs, New Castle
George P. Archer, M.D., Chairman for National Affairs, Prestonsburg
Branham B. Baughman, M.D., Frankfort
Thomas P. Leonard, M.D., Frankfort
Willard Buttermore, M.D., Corbin
William H. Cartmell, M.D., Maysville
Delmas M. Clardy, M.D., Hopkinsville
Robert Shepard, M.D., Lexington
J. Duffy Hancock, M.D., Louisville
O. Leon Higdon, M.D., Paducah
C. C. Howard, M.D., Glasgow
Billy K. Keller, M.D., Louisville
G. David McClure, M.D., Louisville
Marcus Coyle, M.D., Springfield
Wendell Lyon, M.D., Ashland
Charles B. Stacy, M.D., Pineville
Hays Threlkel, M.D., Owensboro
L. O. Toomey, M.D., Bowling Green
John Quertermous, M.D., Murray
Robert B. Warfield, M.D., Lexington
Thomas McElhinney, M.D., Covington

***Associate Committee to Study Medical Examiner System**

Malcolm L. Barnes, M.D., Chairman, Louisville
John D. Allen, Jr., M.D., Louisville
Etta W. Best, M.D., Lexington
William W. Shepherd, M.D., Campbellsville
Edward L. Smith, M.D., Covington

**This Associate Committee reports directly to the Committee on Legislation, and not to the House of Delegates.*

Committee on Third-Party Medicine

Robert W. Robertson, M.D., Chairman, Paducah
Edward B. Mersch, M.D., Covington
Richard Slucher, M.D., Louisville
Clyde C. Sparks, M.D., Ashland
Carlisle Morse, M.D., Louisville

Advisory Committee to the University of Kentucky Medical Center

	Term Expires
O. Leon Higdon, M.D., Chairman Paducah	1960
Harry C. Denham, M.D., Maysville	1962
Byron N. Harrison, M.D., Owensboro	1962
Delmas M. Clardy, M.D., Hopkinsville	1960
Sam A. Overstreet, M.D., Louisville	1960
Jesse T. Funk, M.D., Bowling Green	1962
Branham B. Baughman, M.D., Frankfort	1960
Carl W. Kumpe, M.D., Covington	1961
Coleman C. Johnston, M.D., Lexington	1961
Robert E. Strode, M.D., Winchester	1962
Wendell V. Lyon, M.D., Ashland	1961
Louise Caudill, M.D., Morehead	1961
Paul B. Hall, M.D., Paintsville	1962
Charles B. Stacy, M.D., Pineville	1961
Charles D. Cawood, M.D., Middlesboro	1960
Harold McPheeters, M.D., Louisville	1961
Russell E. Teague, M.D., Louisville	1961
C. C. Howard, M.D., Glasgow	1961

In Memoriam

D. E. ABRAHAM, M.D.
Louisville
1881-1959

Dallas E. Abraham, M.D., a Louisville physician for 52 years, died on October 22 at St. Joseph Infirmary, Louisville, at the age of 78.

Doctor Abraham was graduated from the old Hospital College of Medicine in Louisville in 1906. He was a major in the Army Medical Corps in France during World War I, and was a member of the American Legion. He was a member of the Kentucky State Medical Association.

SAMUEL L. HENSON, M.D.
Benton
1888-1959

Samuel L. Henson, M.D., 71, died on November 1 at Western Baptist Hospital, Paducah. He was Health Officer of Marshall, Calloway, Livingston and Lyon Counties.

A native of Marshall County, Doctor Henson received his medical degree from Vanderbilt University in 1914. He began his practice at the old Illinois Central Railroad Hospital, Paducah, and was a practicing physician for more than 30 years. He was a member of the Kentucky State Medical Association.

O. F. HUME, M.D.
Richmond
1892-1959

A Richmond physician-surgeon, Omer Forest Hume, M.D., died on October 30 at St. Joseph Infirmary, Louisville, after a brief illness. Sixty-seven years old, he had practiced in Richmond for 40 years.

Doctor Hume, a native Washington County, received his medical degree from the University of Louisville Medical School in 1917. He served in the Army Medical Corps in World War I and later was a major in the Kentucky National Guard. He was a brother of Walter Hume, Sr., M.D., and Dr. E. C. Hume, a dentist, both of Louisville.

C. L. NICHOLS, M.D.
Louisville
1881-1959

A physician and surgeon in his native Louisville for 53 years, Clay Lloyd Nichols, M.D., died at his home on November 10. He was 78.

Doctor Nichols was a 1903 graduate of the old Louisville Medical College, where he taught anatomy and was a demonstrator of histology in the early 1900's. He was a district surgeon for the Illinois Central Railroad for 45 years and was on the staffs of Norton Memorial Infirmary, Jewish Hospital and SS. Mary and Elizabeth Hospital.

CARLISLE R. PETTY, M.D.
Louisville
1894-1959

Carlisle Rigdon Petty, Sr., M.D., physician and surgeon in Louisville since 1945, died on October 26 at Jewish Hospital, Louisville, after a brief illness. He was 65.

Doctor Petty was born in Beaver Dam in 1894, the son of a Methodist minister. He was graduated from the University of Louisville Medical School in 1917 and served as a captain in the Army Medical Corps in World War I. Before locating in Louisville, he was chief surgeon at the United States Steel Hospital at Lynch, where he practiced 24 years.

V. G. TRIMBLE, M.D.
Somerset
1877-1959

Retired Somerset physician Volantus Green Trimble, M.D., died on October 9 at the Somerset City Hospital. He was 82.

Doctor Trimble, a native of Somerset, was a veteran of the Spanish-American War. He practiced medicine for many years in Somerset and in Decatur, Ill. Before his retirement about 12 years ago, he was active in various medical organizations.

KSMA Members Participate In Welfare Conference

Several members of KSMA took part in the 47th annual conference of the Kentucky Welfare Association at the Henry Clay Hotel, November 18-20. An estimated 450 persons attended.

J. Duffy Hancock, M.D., Louisville, a member of the Governor's Commision on Aging, presided at the November 18 general session titled "Services to Adults and Aged." Russell Teague, M.D., Commissioner of Health, led a panel discussion on "Medical Services."

Other physicians on the program included Wyatt Norvell, M.D., New Castle, KSMA Councilor; Wilber A. Mitchell, M.D., Louisville, director of the Division of Community Services, Department of Mental Health; Edwin Cameron, M.D., Louisville, director of the Division of Chronic Disease, State Department of Health; Kenneth P. Crawford, M.D., Louisville, chairman of Recreation and Group Work, Health and Welfare Council, and R. O. Joplin, M.D., Louisville.

New Orleans Assembly Set

Prominent physicians from all parts of the country have been booked as speakers for the 23rd annual meeting of the New Orleans Graduate Medical Assembly, March 7-10, 1960, according to a list released by the secretary, Mannie D. Paine, Jr., M.D. Headquarters will be at the Roosevelt Hotel. The meeting will be followed by the 16th annual clinical cruise to the West Indies.

NEWS ITEMS

Bacon R. Moore III, M.D., has begun the general practice of medicine in Harrodsburg, in association with T. O. Meredith, M.D., and J. M. Keightley, M.D. Born in Harrodsburg in 1930, Doctor Moore received his medical degree from the University of Louisville School of Medicine in 1956. He interned at Good Samaritan Hospital, Lexington, after which he served two years in the Army Medical Corps, with the rank of captain.

S. Randolph Scheen, M.D., has opened an office in Medical Arts Building, Louisville, specializing in dermatology. A native of Louisville, Doctor Scheen was graduated from the University of Louisville School of Medicine in 1953 and interned at St. Joseph Infirmary, Louisville. After practicing medicine at Cloverport for two years, he served two-year residencies at Cincinnati General Hospital and the Mayo Clinic. His military service includes three years, 1943-1946, in the U.S. Navy as a Petty Officer 3rd Class.

Douglas David, M.D., director of the Cardiopulmonary Laboratory at St. Joseph Infirmary, Louisville, was co-author with William S. Dye, M.D., Chicago surgeon, of a scientific paper presented at the 67th Annual Meeting of the Western Surgical Association at the Broadmoor Hotel in Colorado Springs, November 19-21. The two collaborated on the original work, "Successful Treatment of Portal Vein Thrombosis Associated With Intra-Hepatic Obstruction." Doctor David attended the Colorado Springs meeting by invitation of the WSC.

H. G. Sargent, M.D., Barlow, has discontinued the practice of medicine in Ballard County, effective November 30. He will take the post of Health Officer for Ballard and McCracken Counties beginning the first of the year.

Samuel S. Shouse, M.D., has been named Lexington-Fayette County Health Officer, after being on loan from the State Department of Health as acting Health Officer since last July. A native of Shelby County, Doctor Shouse was graduated from the Harvard University School of Medicine and the Harvard School of Public Health. He served in the U. S. Navy during World War II.

Mildred E. Gabbard, M.D., who has been serving as health officer of Breathitt, Clay, Owsley, Lee and Wolfe Counties, has relinquished her duties in Breathitt County to take the post of health officer in Jackson County.

An opening for a psychiatrist on the staff of the Medical Division at the California Men's Colony has been announced by George F. Baier, III, M.D., Chief Medical Officer. The new position pays a salary up to $15,000. For further information, write: Chief Medical Officer, California Men's Colony, Los Padres, Calif.



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Student AMA

On the first day of this year, Dr. Sidney I. Kornhauser, long-time professor of anatomy at the University of Louisville Medical School and one of the most beloved members of the faculty, died. For 36 years he had been chairman of the Medical School's Department of Anatomy.

It will soon be a year since Dr. Kornhauser's death and it is only fitting that we remember this man who so freely and willingly gave of himself to the art of teaching. His name must be added to the long list of great and honorable men who have been part of the tradition of our medical school.

Among Dr. Kornhauser's achievements and honors, he was an honorary member of the Jefferson County Medical Society, an honorary member of Alpha Omega Alpha, national medical honor society, and of the Phi Delta Epsilon medical fraternity, whose graduate club established a Kornhauser Scholarship Fund. He was chairman of the school's library committee and headed the selection committee for Rhodes Scholarships. He was founder of and active for many years in the Biological Stains Commission.

These and many others did this man achieve. But one of his greatest attributes was his vast store of knowledge and his willingness to share it with the students. A question asked of Doctor Kornhauser usually resulted in a complete answer and several references where more material could be found.

There are many reasons the students will remember Dr. Kornhauser: The tests he gave—the answers were easy, only the questions were difficult; his characteristic gait, and the way he always smiled when he came into the classroom. The green and orange of the Quad Stain which he invented will keep his memory brightly colored in the minds and microscopes of his students for many years to come.

Gordon Gutmann
Vice-President
U. of L. Chapter, SAMA

OEC Elects KSMA Staff Head

At the annual meeting of the Organization Executives Council, an organization of staff people of trade and professional associations in the Louisville area, KSMA Executive Secretary J. P. Sanford was elected president. Bobbie R. Grogan, KSMA director of Field Services, and William E. Rudd, KSMA executive assistant, are also members of the organization.

KSMA to Be Host to Medical Editors

At the invitation of the Kentucky State Medical Association, the 1960 Southeastern States Medical Journal Conference will be held in Leixngton next October, the exact date to be decided later. Acceptance of the invitation was voted at the 1959 State Medical Journal Conference in Chicago, October 26-27.



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Next page, please . . . . . .

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A A very good question, but it is reassuring to note that in almost two years of clinical use of KANTREX for the treatment of infections for which it is recommended, the emergence of KANTREX-resistant bacterial populations has not been a problem.

Q My impression is that KANTREX *is just another neomycin. Isn't that so?*

A Indeed not. The only thing KANTREX and neomycin have in common is a similar antimicrobial spectrum. Otherwise, they're very different: they have different chemical structures; the toxicity of KANTREX is "much less than that of neomycin"[14]; and clinically, KANTREX Injection is practical for systemic administration routinely, while neomycin is not.

Q You mean that KANTREX *Injection doesn't have the nephrotoxicity of neomycin?*

A Precisely. It's true that when KANTREX Injection is used, urinary casts — even slight albuminuria or microscopic hematuria — may appear, especially in poorly hydrated patients, but this does not reflect any progressive damage to the kidneys. These signs promptly disappear on adequate hydration or termination of therapy.

Q Then why do you recommend reduced dosage in patients with renal impairment?

A Because renal impairment causes an excessive accumulation of KANTREX in the blood and tissues, when usual doses are administered. Since KANTREX Injection is excreted entirely by the kidneys, renal impairment leads to unnecessarily high and prolonged blood levels; and such excessive concentrations increase the risk of ototoxicity.

Q Is that why we see reports of patients developing hearing loss during KANTREX *Injection therapy?*

A Yes. A study of the few reported cases in which patients have suffered impaired hearing will show that in every instance they had pre-existing or concurrent renal impairment, yet received usual or excessive doses of KANTREX Injection. Dosage recommendations for KANTREX Injection emphasize that in patients with renal dysfunction, adequate serum levels can he achieved with a fraction of the dose suggested for patients with normal kidney function — with minimal risk of ototoxicity.

Q Since urinary tract infections are often accompanied by renal impairment, does that mean I shouldn't use KANTREX *Injection in such conditions?*

A Not at all. With proper precautions, KANTREX Injection is an excellent drug for the treatment of urinary tract infections, especially those due to *Proteus, A. aerogenes* and *E. coli*, even when renal impairment is present.

Q What are the "proper precautions" in a patient with impaired renal function?

A The package literature covers them in detail. First, the daily dose should be reduced in such a patient. Then, if he is going to receive KANTREX Injection for 7 days or more, a pre-treatment audiogram should be done, and it should be repeated at appropriate intervals during therapy. If tinnitus or subjective hearing loss develops, or if followup audiograms show significant loss of high frequency response, KANTREX therapy should be discontinued. However, therapy for 7 days or more

is seldom required because the clinical response to KANTREX Injection is so rapid.

Q *Why do you put so much emphasis on* KANTREX'S *"rapid action"? Every antibiotic I've heard about is supposed to be "rapid acting."*

A There is such an abundance of clinical evidence about "rapid acting" that it takes KANTREX Injection out of the "supposed-to" class.[1,2,3,7,8,9,11,15,16,19,21,22,26,29,32,33] Remember, the effectiveness of KANTREX Injection therapy can usually be appraised in 24 to 36 hours. That's definite evidence of rapid action. In fact, one group of investigators reported that "the rapidity with which bacteria are killed by this agent is reflected by the promptness of the clinical response."[29]

Q *Does* KANTREX *Injection cause blood dyscrasias?*

A In extensive clinical and toxicity studies by numerous investigators, as well as almost two years of general use, not a single instance of such toxicity has been reported.

Q *Can I administer* KANTREX *Injection in any other way than by the intramuscular route?*

A Yes. While it's usually given intramuscularly, other routes are practicable: intravenous, intraperitoneal, by aerosol, and as an irrigating solution. Complete instructions are included in the package insert.

Q *So you think I ought to use* KANTREX *Injection as my first choice antibiotic in staph and gram-negative infections?*

A Yes – because all evidence to date indicates that it is bactericidal against a wide range of organisms…rapid acting…does not encourage development of bacterial resistance…is well tolerated in specified dosage…and has not caused any blood dyscrasias.



KANTREX CAPSULES

for local gastrointestinal therapy…
not for systemic infections

Q *Why can't I use* KANTREX *Capsules for systemic medication?*

A Because there is only negligible absorption of KANTREX from the gastrointestinal tract.[3,5,6,8,28,31] Thus, capsules cannot provide effective blood levels.

Q *Then what are* KANTREX *Capsules used for?*

A Preoperative bowel sterilization, and local treatment of intestinal infections due to kanamycin-sensitive organisms.

Q *I've been using neomycin for preoperative bowel sterilization. Why should I switch to* KANTREX *Capsules?*

A Because KANTREX has been rated as "superior to neomycin" for this purpose.[6] It provides rapid and satisfactory control of coliforms, clostridia, staphylococci and streptococci; yeasts do not proliferate; stool concentrations of the drug are exceptionally high; and nausea, vomiting or intestinal irritation have not been observed.[5,6]

Q *What advantages do* KANTREX *Capsules offer me in the treatment of intestinal infections?*

A A high degree of effectiveness against most of the pathogens responsible for such infections: *Salmonella*, *Shigella*, *Staph. aureus*, *E. coli* and *Endamoeba histolytica*. Moreover, their use has been "remarkably free of any side effects."[31]

KANTREX

INJECTION KANAMYCIN SULFATE INJECTION

INDICATIONS
Infections due to kanamycin-sensitive organisms, particularly staph or "gram-negatives"; genito-urinary infections; skin, soft tissue and post-surgical infections; respiratory tract infections; septicemia and bacteremia; osteomyelitis and periostitis.

DOSAGE: INTRAMUSCULAR ROUTE
Recommended daily dose is 15 mg. per kg. of body weight, in 2 to 4 divided doses.

For intramuscular administration, KANTREX Injection should be injected deeply into the upper outer quadrant of the gluteal muscle.

TOXICITY
When the recommended precautions are followed, the incidence of toxic reactions to KANTREX is low. In well hydrated patients under 45 years of age with normal kidney function, receiving a total dose of 20 Gm. or less of KANTREX, the risk of ototoxic reactions is negligible.

In patients with renal disease and impaired renal function, the daily dose of KANTREX should be reduced in proportion to the degree of impairment to avoid accumulation of the drug in serum and tissues, thus minimizing the possibility of ototoxicity. In such patients, if therapy is expected to last 7 days or more, audiograms should be obtained prior to and during treatment. KANTREX therapy should be stopped if tinnitus or subjective hearing loss develops, or if audiograms show significant loss of high frequency response.

OTHER ROUTES OF ADMINISTRATION
KANTREX should be used by intravenous infusion only when the intramuscular route is impracticable. KANTREX can also be employed for intraperitoneal use, aerosol treatment, and as an irrigating solution. See package insert for directions.

PRECAUTIONS
Use of antibiotics may occasionally result in overgrowth of non-sensitive organisms. If superinfection appears during therapy, appropriate measures should be taken.

SUPPLY
Available in rubber-capped vials as a ready-to-use sterile aqueous solution in two concentrations (stable at room temperature indefinitely):

KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in 2 ml. volume.
KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in 3 ml. volume.

CAPSULES (for local gastrointestinal therapy; not for systemic medication)

INDICATIONS AND DOSAGE
For preoperative bowel sterilization: 1.0 Gm. (2 capsules) every hour for 4 hours, followed by 1.0 Gm. (2 capsules) every 6 hours for 36 to 72 hours.

For intestinal infections: Adults: 3.0 to 4.0 Gm. (6 to 8 capsules) per day in divided doses for 5 to 7 days. Infants and children: 50 mg. per kg. per day in 4 to 6 divided doses for 5 to 7 days.

PRECAUTION
Preoperative use of KANTREX Capsules is contraindicated in the presence of intestinal obstruction. Although only negligible amounts of KANTREX are absorbed through intact intestinal mucosa, the possibility of increased absorption from ulcerated or denuded areas should be considered.

SUPPLY
KANTREX Capsules, 0.5 Gm. kanamycin (as sulfate), bottles of 20 and 100.

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KSMA Lists New Members

The names of seven physicians have been added to the KSMA membership list since The Journal's last report. They are:

Carroll C. Brooks, M.D., Bowling Green
Steve C. Cuff, M.D., Bowling Green
Edwin T. Davis, M.D., Paducah
Nicholas Z. Kafoglis, M.D., Bowling Green
Bacon R. Moore, III, M.D., Harrodsburg
Donald H. Mosley, M.D., Lyndon
George E. Walker, M.D., Middlesboro

GP Seminar Held At Campbellsville

Approximately 50 physicians attended the regional seminar of the Kentucky Academy of General Practice held on November 12 at Campbellsville College, Campbellsville. Roy G. Wilson, M.D., Campbellsville, was chairman of the meeting.

Speakers included Isador Dyer, M.D., Tulane University, New Orleans; George Mann, M.D., Vanderbilt University, Nashville; Harry C. Shirkey, M.D., Birmingham, Ala.; Norman K. Cohen, M.D., Louisville, and William Hambley, M.D., Pikeville.

Ashland M.D. Gets Korean Medal

An Ashland physician, U. S. Army Captain Louis Putnam, was decorated recently by President Syngman Rhee of South Korea. Doctor Putnam, who served as one of Rhee's personal physicians during his assignment in Korea the past year, received the Order of Military Merit Choongmoo with gold star. He was cited for volunteering his off-duty time "to serve as medical consultant, specialist and advisor to the Republic of Korean government and Army medical personnel." Doctor Putnam was scheduled to leave Korea November 10 for reassignment in Washington, D. C.

Dr. Smith Named to SAMA Council

Austin E. Smith, M.D., president of the Pharmaceutical Manufacturers Association of Washington, D.C., has accepted appointment to the National Advisory Council of the Student American Medical Association, according to announcement by R. F. Staudacher, Chicago, executive director of SAMA. He will fill the office left vacant by the death of Warren E. Furey, M.D., Chicago. Doctor Smith is a former editor of The Journal of the American Medical Association.

The American College of Physicians has scheduled its meetings for 1960 and 1961. The 1960 meet will be held April 4-8 in San Francisco, California. Bal Harbour, Florida, will be the site of the 1961 meeting on May 8-12, with headquarters in the Americana Hotel.

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Your prescription filled by us will be processed to the prescription with first quality materials; the glass and surfaces will be tested for precision of workmanship—and your lenses checked for accuracy of power —only a perfect lens passes the Southern Optical test.



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Results with ". . . antacid therapy with DAA are essentially the same as . . . with potent anticholinergic drugs."

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In recent years, a number of new synthetic anticholinergic drugs with numerous and varying side effects have been investigated for treatment of peptic ulcer. However, a double-blind study conducted recently by Cayer et al suggests that the use of such anticholinergic drugs is seldom necessary. The authors concluded that "The percentage of 'good to excellent' results obtained in patients on continuous long-term antacid therapy with DAA (74%) is essentially the same as that previously noted in ulcer patients treated under similar conditions with potent anticholinergic drugs alone."

The authors' choice of dihydroxy aluminum aminoacetate (DAA) was based on the fact that "the tablet form of DAA (is) more active than a variety of straight aluminum hydroxide magmas." They further commented that "Because of the convenience of tablet medication as compared with the liquid gel—a convenience which in the use of other tablets is gained at the expense of therapeutic effectiveness—dihydroxy aluminum aminoacetate was used exclusively."

ALGLYN (dihydroxy aluminum aminoacetate) Tablets are supplied in bottles of 100 tablets (0.5 Gm. per tablet).

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County Society Report
McCracken County

A proposal to present a food-handlers ordinance to the City Commissioners and plans for tuberculin testing in the public schools was reported by Harold Priddle, M.D., Paducah, chairman of the Public Health Department of the Representatives Committee, at the regular monthly meeting of the McCracken County Medical Society September 16. Norman A. Parrott, M.D., Paducah, announced that the County Tuberculosis Association had contributed $4,000 to pay for a full-time nurse. This program was unanimously approved by the society.

A letter from Garnett Sweeney, M.D., Liberty, chairman of the KSMA Council, asked the society's view on whether or not the KSMA should conduct a Relative Value Study in Kentucky. A copy of the California Relative Value Study was attached for members to see.

K. L. Barnes, M.D., Princeton, chairman of Committee on Technical Exhibits, requested through a letter that all members attend the Annual Meeting in Louisville and visit the technical exhibits.

A resolution from John W. Turner, M.D., Paintsville, president of the Johnson County Medical Society, proposed the nomination of Paul B. Hall, M.D., Paintsville, as a candidate for president of the Kentucky State Medical Association.

The society's correspondence also included a letter from Edwin Cameron, M.D., Louisville, director of the Division of Chronic Disease Control, State Department of Health, asking physicians participating in the survey on rheumatic fever to return their cards, whether completed or not.

A new pamphlet entitled, "The Healthy Way to Weigh Less" has just been produced by the American Medical Association. In announcing the booklet, the AMA said, "Because of the medical implications of obesity and the problem of restraining the promoters of "short cuts" to weight reduction, we are confident the medical profession will play a leading role in alerting the public to both of these dangers." Members wishing a supply of pamphlets to distribute to their patients and the public may obtain them by contacting the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

The Deafness Research Foundation has announced initial grants of $13,240 from the Foundation funds for basic research in hearing and deafness. The Foundation, established less than a year ago, is the only national voluntary health organization, founded and governed by laymen, devoted primarily to fundamental research in the causes, prevention and cure of deafness.



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CHOICE THERAPY FOR THE "OLDER" PATIENT WITH MILD TO MODERATE HYPERTENSION



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More than 13,000,000 prescriptions attest that Veratrite continues to be the antihypertensive of choice for the older hypertensive patient. Veratrite can be prescribed safely and routinely for those who usually cannot tolerate more potent drugs.

Veratrite now contains cryptenamine which acts centrally to produce a gradual fall in blood pressure, yet improves circulation to vital organs, relieves dizziness and headache, and imparts a distinct sense of well-being. Furthermore, Veratrite achieves its effects with unusual safety and without annoying side effects.

Each Veratrite tabule contains: Cryptenamine (tannates), 40 C.S.R.* Units; Sodium nitrite, 1 gr.; Phenobarbital, ¼ gr. Dosage: 1–2 tabules t.i.d., preferably 2 hours after meals.

*Carotid Sinus Reflex

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Striking relief
from LOW BACK PAIN
and DYSMENORRHEA
THE FIRST TRUE "TRANQUILAXANT"
Trancopal

Here is what you can expect when you prescribe

for dysmenorrhea

and premenstrual tension

Case Profile*

A 28-year-old married woman, a secretary in a booking agency, complained of severe and consistent pain and cramps in the abdomen during her menstrual periods. Psychologically, she described the first two days as "climbing the walls." Menarche occurred at age 13. She has a regular twenty-eight day menstrual cycle and a four day menstrual period.

Trancopal was given in a dose of 100 mg. four times a day for the first two days of the four day period. In addition to the relief of the dysmenorrhea she also noticed disappearance of a "bloated feeling" that had previously annoyed her. She has now been treated with Trancopal for one and one-half years with excellent results. Other medication, such as codeine or aspirin with codeine, had relieved the pain, but the patient had had to stay home. Because her father is a physician, many commercial preparations had been tried prior to Trancopal, but no success had been achieved.

Before taking Trancopal this patient missed one day of work every month. For the past year and a half she has not missed a day because of dysmenorrhea.



THE FIRST TRUE "TRANQUILAXANT"

Trancopal®

for low back pain



Case Profile*

A 42-year-old truck driver and mover injured his back while moving a piano. The pain radiated from the sacral region down to the region of the Achilles tendon on the right side. X-rays for ruptured disc revealed nothing pertinent. The day of the injury he was given Trancopal immediately after the physical examination. Although 100 to 200 mg. three times a day were prescribed, the patient on his own responsibility increased the dosage of Trancopal to 400 mg. three times a day. This dosage was continued for three days and then gradually reduced over a ten day period. During this time, the patient continued to drive his truck. The muscle spasm was completely controlled and no apparent side effects were noted.

For the past six months, the patient has continued to take Trancopal 100 to 200 mg. as needed for muscle spasm, particularly during strenuous days.

**Clinical Reports on file at the Department of Medical Research, Winthrop Laboratories.*

Turn page for complete listings of Indications and Dosage.

THE FIRST TRUE "TRANQUILAXANT"

Trancopal

potent MUSCLE RELAXANT

effective TRANQUILIZER

- In musculoskeletal disorders, effective in 91 per cent of patients.[1]
- In anxiety and tension states, effective in 89 per cent of patients.[1]
- Low incidence of side effects (2.3 per cent of patients). Blood pressure, pulse rate, respiration and digestive processes are unaffected by therapeutic dosage. It does not affect the hematopoietic system or liver and kidney function.
- No gastric irritation. Can be taken before meals.
- No clouding of consciousness, no euphoria or depression.

Indications [1-6]

Musculoskeletal:

Low back pain (lumbago, etc.)
Neck pain (torticollis)
Bursitis
Rheumatoid arthritis
Osteoarthritis
Disc syndrome
Fibrositis
Ankle sprain, tennis elbow
Myositis
Postoperative muscle spasm

Psychogenic:

Anxiety and tension states
Dysmenorrhea
Premenstrual tension
Asthma
Angina pectoris
Alcoholism

Now available in two strengths:



Trancopal Caplets®,
100 mg. (peach colored, scored), bottles of 100.

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Trancopal Caplets,
200 mg. (green colored, scored), bottles of 100.

Dosage: Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

Winthrop LABORATORIES
New York 18, N. Y.

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Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off. 1408M Printed in U.S.A.





the disease of many masks

Doctor, do you recognize this patient? She complains of flatulence, constipation with alternating periods of diarrhea, and colicky pains in the lower right quadrant. At other times she is troubled by anorexia, lassitude, dull headache, muscle pains and backache. Or she may have only one or two of these symptoms.

In these puzzling cases, serious consideration should be given to intestinal amebiasis—the disease of many masks. Clinicians say it is "one of the most widespread and serious protozoan diseases of man," yet "there is no parasite more often misdiagnosed than is *E. histolytica*." Conservative estimates place the incidence at 10% of the United States population as a whole, and 16% in southern states.

Now Glarubin, a relatively non-toxic amebicide, simplifies the treatment of suspected cases of intestinal amebiasis. Glarubin, a crystalline glycoside from the fruit of *Simarouba glauca*, is a specific amebicidal agent with minimal side effects. It contains no arsenic, bismuth or iodine.

Glarubin is administered orally in tablet form and does not require strict medical supervision or hospitalization. Extensive clinical trials prove it highly effective in intestinal amebiasis, and virtually free of toxicity.

Supplied in bottles of 40 tablets, each tablet containing 50 mg. of glaucarubin. Write for descriptive literature, bibliography, and dosage schedules.

new Glarubin

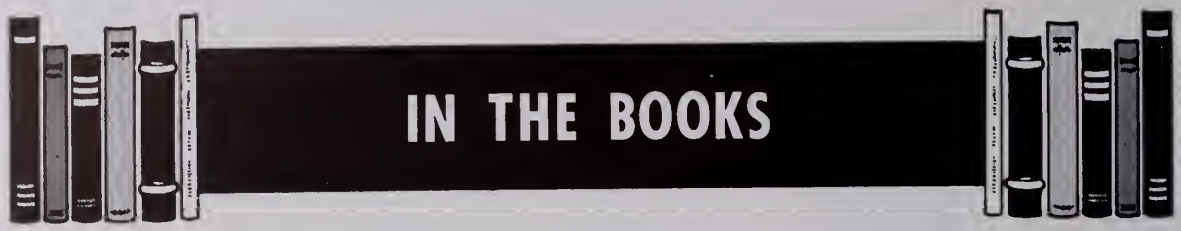
TABLETS

specific for intestinal amebiasis

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SYNOPSIS OF EAR, NOSE AND THROAT DISEASES: by Robert E. Ryan, M.D.; William C. Thornell, M.D., and Hans von Leden, M.D.; published by C. V. Mosby Company, St. Louis, Mo., 1959; 383 pages; price, $6.75.

This is a brief synopsis of ear, nose and throat diseases written to be of interest as a handy guide for the general practitioner, intern, medical student, nurse, and speech therapist.

The material is divided into the ears, nose and sinuses, the pharynx, and the larynx. There is a concise review of anatomy and physiology preceding each section. The anatomical material is excellent. Surgical procedures are very briefly described.

The section on headaches is very good. It is probable that the section on chronic otitis media will be difficult for many to understand. The surgical descriptions are too brief and are not up to date due to the rapidly increasing knowledge of ear surgery. The information on epistaxis will offer little of value to the general practitioner. The use of drugs is advocated, but they have proved to be of little value.

The role of postnasal packs is minimized although they are of utmost importance in posterior bleeding. With antibiotics, infection due to postnasal packs has been minimized. The technique described for inserting a pack leaves much to be desired.

On the whole, this book will prove a valuable guide to the busy general practitioner on ear, nose and throat problems.

Roy A. Martin, M.D.

SURGERY OF THE FOOT: by Henry L. DuVries, M.D., Louisville; published by C. V. Mosby Company, St. Louis, Mo., 1959; 494 pages; price, $12.50.

This is a book, as evidenced from its title, that is devoted to a discussion of disabilities of the foot as well as surgical correction of these disabilities. The first three chapters of the eighteen chapters are devoted to basic fundamentals concerning: (1) Structure and Function of the Foot; (2) Examination and Diagnosis, and (3) Operation Principles and Requirements. The subsequent fifteen chapters are devoted to different specific disorders and diseases of the soft tissue and osseous structure of the foot.

The book is well illustrated and has 403 figures, all of which are well done. In context the subject matter is easy to read and assimilate. This would be true not only for the orthopedist but the general surgeon and general practitioner as well.

The author discusses many of the minor foot problems in somewhat more detail than other texts. In contrast, however, some of the major foot disabilities are treated rather lightly and in considerably less detail than they should be. In discussing surgical technique the author in many instances describes his own operation as the procedure of choice and these in turn are detailed. Many other operations, which can be done for the same condition, are only mentioned in passing or not at all. This may be good in that at least a method is advocated and detailed sufficiently so that it can be followed rather simply. On the other hand, other operations which have been invented for the same condition give equally good results. I feel that a more detailed description of generally accepted procedures could be incorporated than has been.

The book would make a good reference book for those physicians who are interested in surgery of the the foot.

Daniel G. Costigan, M.D.

MOLOY'S EVALUATION OF THE PELVIS IN OBSTETRICS: by Charles M. Steer, M.D., Med.Sc.D., F.A.C.S., F.A.C.O.G.: published by W. B. Saunders Company, Philadelphia and London, 1959; 131 pages; price, $4.00.

The purpose of this monograph is to measure some of the parts of clinical judgment and intuition concerning cephalopelvic disproportion in order to guide the operator in choosing the proper method of delivery in the individual case.

A large section is devoted to the general morphology of the pelvis and to classification. This is well illustrated. A method of clinical evaluation is described, which makes it possible to classify the pelvis in the majority of individuals and which assists in selection of patients for roentgenologic examination at term or in early labor.

The mechanism of labor is described and factors influencing the arrest of labor in the various types of pelves are analyzed and related to the morphology of the pelvis. The method of treatment is then guided by the knowledge of the configuration of the pelvis. This includes arrest in the transverse and posterior positions in the midpelvis and low midpelvis.

In order to recognize absolute or relative cepholopelvic disproportion in those cases which have clinically inadequate pelves, a technic of X-ray pelvimetry, which allows measurement of all pelvic diameters and the fetal head and which shows the true shape of the pelvis, is described. The information, obtained as close to the time of delivery as possible, helps to determine the type of trial labor and the management of labor in cephalic presentation. This will

In the Books

help to reduce fetal and maternal mortality and morbidity.

The methods are not as applicable in breech presentation, because of the inability to determine accurately the size of the fetal head consistently.

This monograph is well illustrated and the information is based on case studies. Any physician who is particularly interested in obstetrics will find it both interesting and helpful.

W. Procter Eubank, M.D.

Books Received

Following is a list of books received by the Association for review. Those considered of particular interest to Journal readers will be reviewed as space permits. All complimentary copies of books received are turned over to the University of Louisville-Jefferson County Medical Society Library. Inquiries concerning a particular book should be made to the KSMA Headquarters Office, 1169 Eastern Parkway, Louisville 17, Ky.

BIOPSY MANUAL: by James D. Hardy, M.D.; James C. Griffin, Jr., M.D., and Jorge A. Rodriguez, M.D.; published by W. B. Saunders Company, Philadelphia and London.

METABOLIC CARE OF THE SURGICAL PATIENT: by Francis D. Moore, M.D., and Mildred Coddling, A.B., M.A.; published by W. B. Saunders Company, Philadelphia and London.

THE PHYSICIAN AND THE LAW: by Rowland H. Long; published by Appleton-Century-Crofts, Inc., New York.

SYMPOSIUM ON GLAUCOMA: William B. Clark, M.D., F.A.C.S., editor; Joe M. Carmichael, M.S.J., associate editor; published by the C. V. Mosby Company, St. Louis.

ATLAS OF ROENTGENOGRAPHIC POSITIONS: by Vinita Merrill; published by the C. V. Mosby Company, St. Louis.

LABORATORY TESTS IN COMMON USE: by Solomon Garb, M.D.; published by Springer Publishing Company, Inc., New York.

A report issued by the Health Insurance Institute on a study conducted by the Life Extension Examiners indicates that in the last 15 years the number of overweight executives has been reduced a third. Dr. Harry Johnson, medical director of the Life Extension Examiners, attributed the change to the fact that the executives have been made aware of the importance of keeping their weight down as a part of total personal health. Business and industry sponsored health programs, through regular health examinations, have focused attention on this help-yourself phase of staying well. He called overweight the outstanding health hazard in America today, and said, "By keeping his weight down, the executive has made himself less vulnerable to such over-forty disablers as heart disease, diabetes, and high blood pressure."

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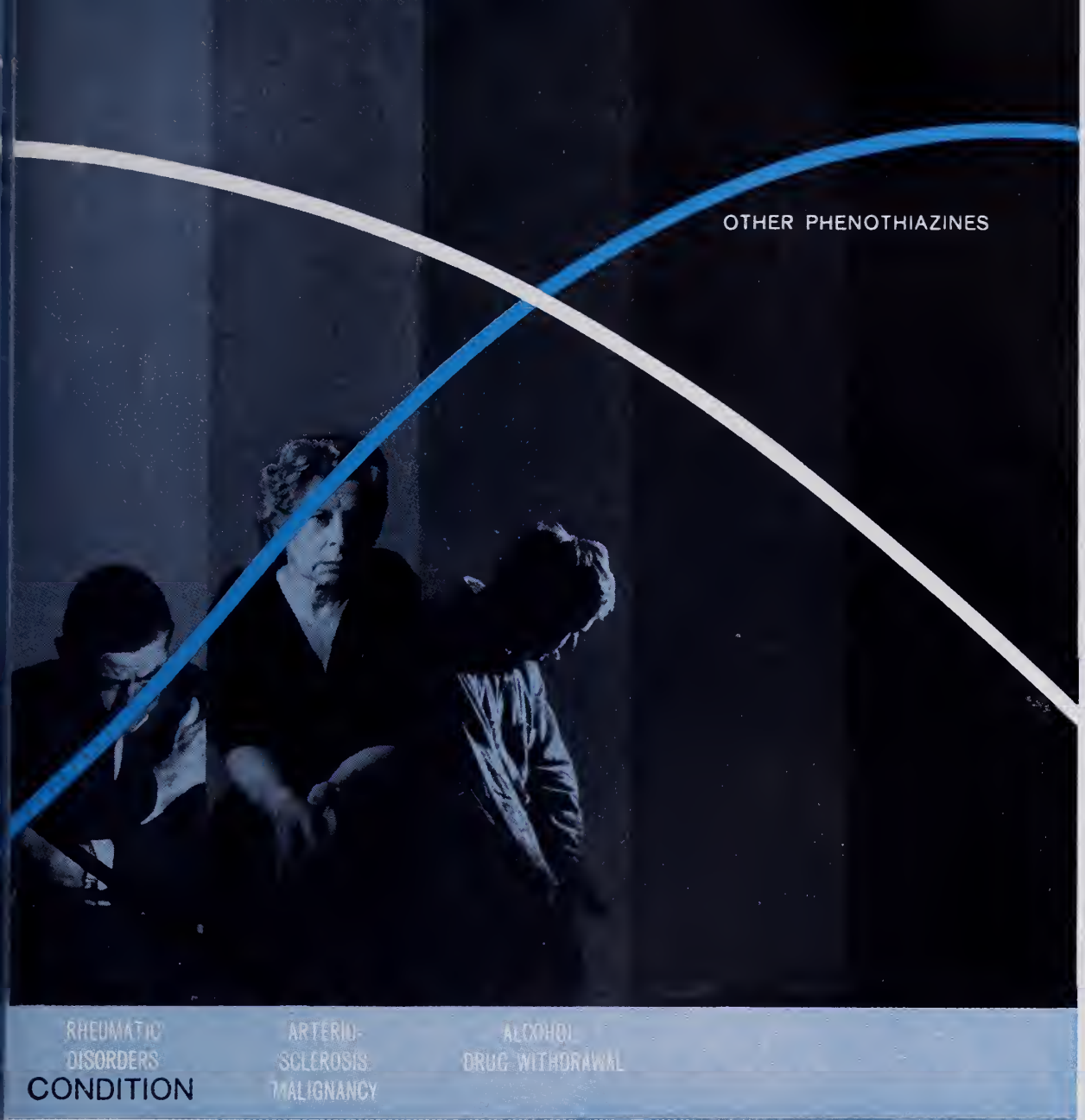
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1. Bodi, T., and Levy, H.: Clinical report, cited with permission. 2. Wetzler, R. A., and Phillips, R. M.: Clinical report, cited with permission. 3. Prigot, A.: Clinical report, cited with permission. 4. Gosline, E., *et al.*: *Am. J. Psychiat.* 115:939 (April) 1959. 5. Turvey, S. E. C.: Clinical report, cited with permission.

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PUBLIC HEALTH PAGE

The Use Of Duck Embryo Vaccine For Rabies Prophylaxis In Man

RUSSELL E. TEAGUE, M.D.

Commissioner of Health,
Commonwealth of Kentucky

RABIES-CONTROL programs are primarily designed to eliminate the disease in animals. Until this goal is achieved, the problem of treating humans following exposure is an ever present hazard. Since the time of Pasteur, active immunization following exposure has been accepted practice, using vaccines prepared from central nervous system tissue of infected animals.

The use of this vaccine is not without danger since complication sensitivity reactions may occur. Also, the incubation period may be too short to accomplish adequate active immunity. For these reasons, investigation into primary immunization against rabies has been studied during the last several years.

A recent development is the use of hyperimmune serum in cases of severe exposure in order to protect the patient by passive immunity after severe bites or where a short incubation period is anticipated. More recent developments include the use of vaccines prepared from chicken or duck embryos instead of conventional central nervous system tissue vaccines.

In 1955, Bruce Peck, Jr., and his group described the use of duck egg antirabies vaccine in humans. The results indicated that rabies vaccine of duck embryo origin produced neutralizing antibody in practically all subjects within ten days and was found to be free of neuroparalytic factors. That potency tests of several lots indicated that the vaccine consistently surpassed by two or three times the standard vaccine of the National Institutes of Health. As a result, the duck embryo vaccine was licensed for commercial production and is now generally available.

Human exposure to rabies occurs frequently as indicated by the fact that several hundred individuals are required to take Pasteur treatment each year in Kentucky.

In view of these facts, a program was designed by which the booster effect of one or two doses of rabies vaccine was tested on previously immunized individuals. Furthermore, since practically nothing was known concerning the primary immune response to spaced doses of duck embryo vaccine, a group of veterinarians also received a 3-dose course of vaccine.

The entire group of veterinarians was divided according to their previous vaccine experience into four groups. Eight individuals in the study had received more than one 14-dose course of rabies vaccine. All of these individuals had good prebooster circulating antibody.

Nine individuals who had received one previous 14-dose course, and who were given one booster dose of duck embryo vaccine, also responded with a prompt antibody response. This response appears to be every bit as good as was seen in the first group.

Another group composed of six patients who had previously received one 14-dose course of therapy were given two injections of duck embryo vaccine at an interval of seven days. All of these individuals showed a rise in antibody titer one week following the second dose of vaccine.

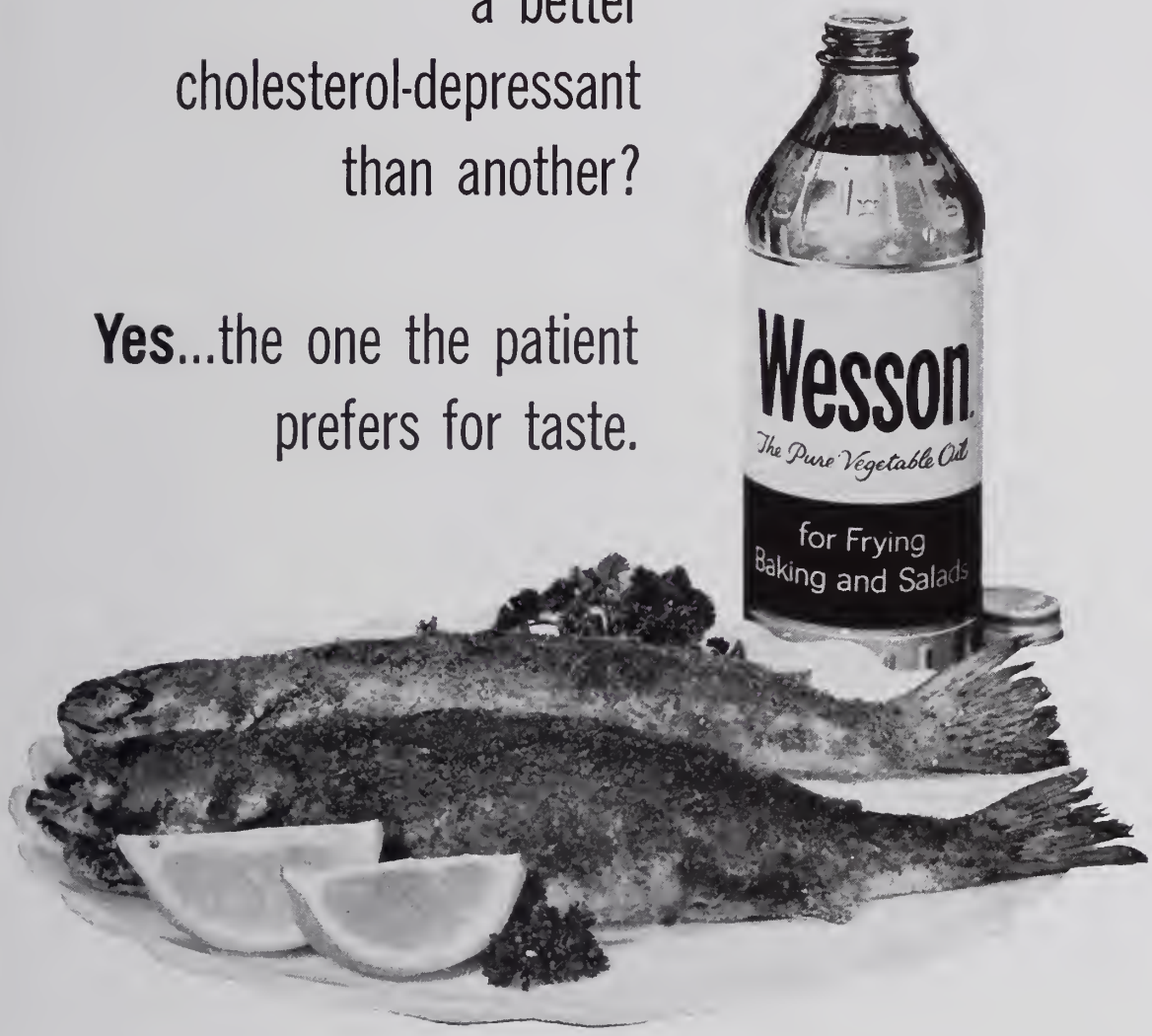
A fourth group had never at any time received antirabies treatment. They were given three 1 cc subcutaneous injections of duck embryo rabies vaccine. The first two injections were spaced two weeks apart and the third injection was given thirty days after the second. Of the twenty-one individuals in the group, eighteen responded with detectable circulating antibody which appeared sometime during the period of blood collecting. Approximately one year after the primary immunization of these individuals, two intradermal booster injections of duck embryo were administered to ten of these patients. The injections were given at two-week intervals. The post-booster bleeding indicates that these individuals exhibited a good but not 100% response.

The data showing antibody response to booster injections of duck embryo vaccine indicates that there is a prompt rise in neutralizing antibody titer provided the individual has had at least one 14-dose course of potent rabies vaccine. This data also adds to the growing evidence that it is probably only necessary to receive one or two booster injections following exposure once a good basic immune mechanism has been established by at least one 14-dose course of potent antirabies vaccine.

The most important problem is to be absolutely sure that a good basic immunity has been established. Because of the occasional nonresponder it is difficult to make a blanket recommendation concerning primary prophylactic immunization. It appears that some type of screening procedure will be needed to determine when a good antibody response has been achieved.

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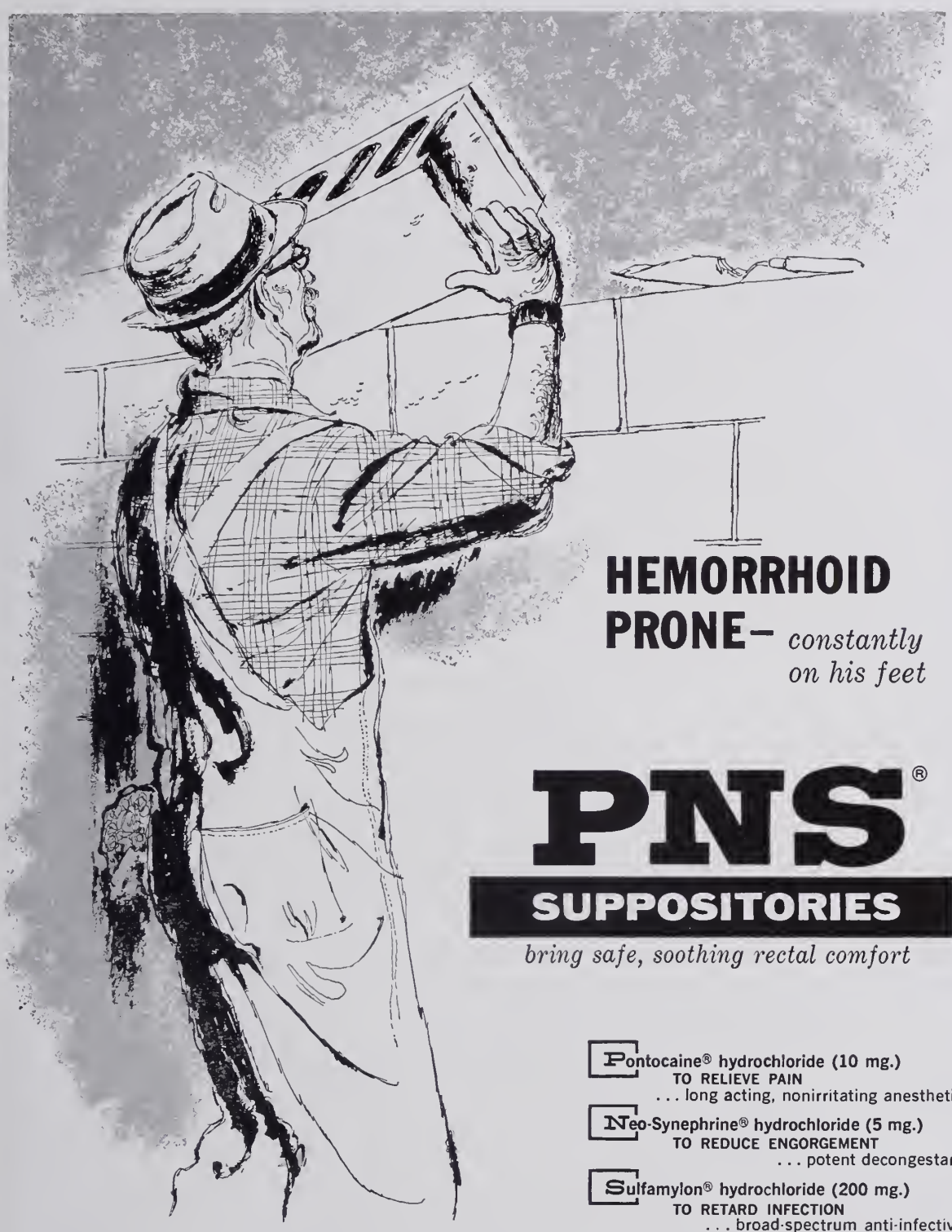
Dosage:

Adults—2 to 4 tablets or tsp. initially, followed by 2 tablets or tsp. every 4 to 6 hours until the patient has been afebrile 3 days. *Children 8 to 12* — 2 tablets or tsp. initially, followed by 1 tablet or tsp. every 6 hours. *Children under 8*—dosage according to weight.

The palatability, convenience and effectiveness of the Suspension make it especially suitable for children and for those older patients who prefer liquid medication.

References: 1. Cecil, R. L., et al.: J.A.M.A. 124:8 (Jan. 1) 1944. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Beckman, H.: Drugs, Their Nature, Action & Use, Saunders, Philadelphia, 1958, p. 527.

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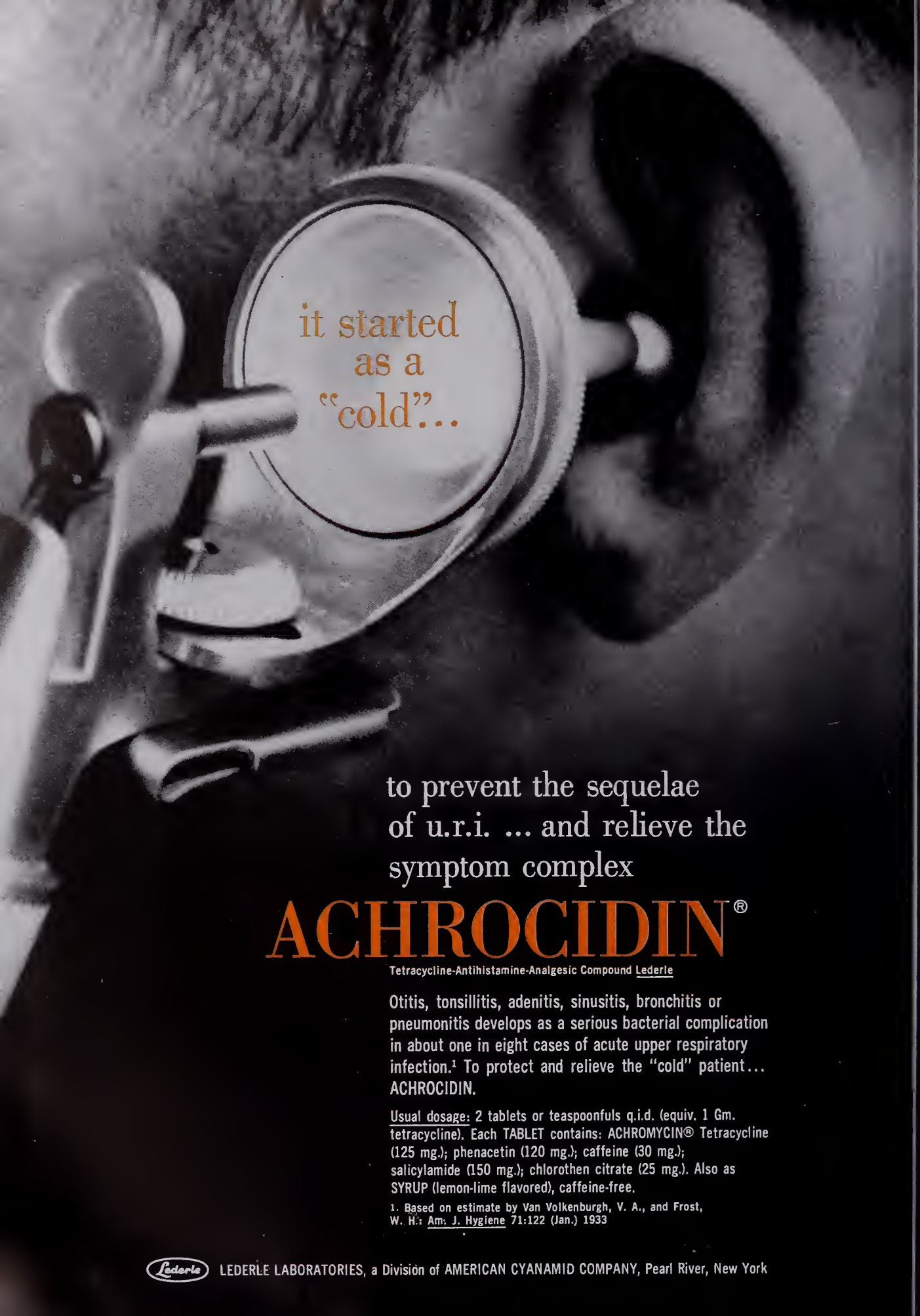
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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933

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1959 CONSTITUTION AND BYLAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Revised September 23, 1959

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition of the Association
Article V. House of Delegates
Article VI. Sections and District Societies
Article VII. Sessions and Meetings
Article VIII. Officers
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Meaning of Term "County Societies"

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Sessions of the Association
Chapter III. General Meeting
Chapter IV. House of Delegates
Chapter V. Election of Officers
Chapter VI. Duties of Officers
Chapter VII. The Council
Chapter VIII. Committees
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and the advancement of medical science and charity, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest; to protect the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies and the House of Delegates shall have authority to adopt Bylaws regulating the admission and classification of members as deemed advisable.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt Bylaws to carry out the provisions of this Constitution.

Section 2. Delegates shall be members of and elected by component societies in accordance with the Bylaws. Officers of the Association, Delegates and Alternate Delegates to the American Medical Association, and the five immediate Past Presidents shall be ex officio members of the House of Delegates and entitled to vote.

Section 3. The speaker or vice-speaker shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the Bylaws of the Association.

Article VIII. Officers

Section 1. The officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other officers as provided for in the Bylaws.

Section 2. The officers of the Association shall serve for the term of office and subject to provisions as specified in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. The officers of the Association shall be elected by the House of Delegates at the annual session of the Association and shall take office on the last day of the annual meeting.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county (component) society to be fixed by the House of Delegates by voluntary contribution and from other sources of revenue. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Meaning of Term "County Societies"

Anywhere in the Constitution, Articles of Incorporation, or Bylaws in which the term county society, or county societies, component county society or component medical society appears, it shall be construed to mean component society.

BYLAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association, the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by the county society, be accepted by KSMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Council shall have power, upon written application, approved annually by the county society in which the applicant resides, to excuse any member from the payment of dues because of financial hardship.

Section 2. Membership in the Association shall be divided into six classes, to wit: Active, Associate, Inactive, Emeritus, Student, and Honorary.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component county medical societies. To be eligible for active membership in any component county society, the applicant must be a doctor of medicine of good moral, ethical, and professional standing, who is licensed to practice medicine in Kentucky.

(b) Associate Members. The associate membership of the Association shall consist of the associate members of the various component county medical societies. To be eligible for associate membership in any component county society, the applicant must be ineligible for active membership and qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

(2) Interns, residents or teaching fellows who are doctors of medicine and who have complied with all pertinent regulations of the State Board of Health.

County societies may also invite dentists, pharmacists, funeral directors, or other professional persons to become associate members.

Associate Members shall not have the right to vote nor to hold office, but shall receive The Journal and other publications of the Association.

(c) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county medical societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive The Journal and other publications of the Association.

(d) Emeritus Members. Component societies may elect as a member-emeritus any doctor of medicine who is 70 years of age or who has retired from active practice and who has previously maintained active membership in good standing in his own society for twenty years or more. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues, nor shall they be entitled to the benefits of Chapter VII, Section 10 of these Bylaws. They shall receive The Journal and other publications of the Association.

(e) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in any accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. Student members shall receive The Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

(f) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege of the floor in all scientific sessions.

Section 3. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 4. The name of a physician upon the properly certified roster of members or list of delegates of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 5. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership, shall be entitled to any of the rights or benefits of this Association or its proceedings until such time as he has been relieved of such liability.

Section 6. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an annual session and such special session at such times and places as may be determined by the House of Delegates. All sessions shall be limited to the scientific, educational, legislative, economic and business activities of the Association. Such special sessions shall be held in accordance with the provisions of Chapter IV, Section I of the Bylaws.

Chapter III. General Meeting

The General Meeting shall include all registered members and guests. Although only active members shall have the right to vote on pending questions all members shall have equal rights to participate in the

proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by the President-Elect or one of the Vice-Presidents. The annual address of the President shall be delivered at such time and place during the annual session as the Council may direct. The entire time of the sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Chapter IV. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the Association and profession require, it may meet in advance of or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on the written request of delegates representing fifty or more component county societies. When such special session is called, the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session. The Speaker of the House shall, by virtue of his office, be responsible for making all arrangements for any special session of the House of Delegates.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. Each resolution introduced into the House of Delegates shall be in writing and signed by the author and presented to the Secretary following its introduction. If the author be an individual member, it shall be signed by him. If the author be a group of members, it shall be signed by the authorized spokesman for that group. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 5. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 6. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 7. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 8. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 9. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 10. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 11. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and Bylaws.

Section 12. The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2—Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10—Fayette, Jessamine, and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

Councilor district meetings may be held as desired, and District Medical Associations may be organized as desired according to the districts outlined above.

Section 13. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the

House of Delegates in person, and may participate in the debate thereon.

Section 14. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 15. A digest of proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice-Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates, or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Section 5. During the last session of the House of Delegates the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as chairman at an organization meeting held during the County Society Officers' Conference, or at some other appropriate place designated by the Council at least four months before the Annual Meeting. The Committee, in addition to such other sessions as it may choose to hold, will schedule an open meeting immediately after the close of the first session of the House of Delegates at each Annual Meeting. This open session shall be held in the same meeting hall, shall receive broad publicity, and those who have business to discuss with the Committee shall have a hearing. Following this meeting, the Committee shall announce its final recommendations at the beginning of the second scientific session the following day, the Committee submitting one or more names for each officer to be elected. The House of Delegates will vote on the nominees at its second session. Additional nominations may be made from the floor by submitting the nominations without discussion or comment.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President, in an amount not to exceed the total amount appropriated for that purpose in the annual budget.

Section 2. The President-Elect shall be ex officio a member of the Committee on Scientific Assembly and Arrangements, and of the House of Delegates with the right to vote, and shall assist the President in visitation of county and other meetings. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. In the event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation, or removal, the Council shall elect one of the Vice-Presidents to succeed him. The Vice-Presidents, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for the traveling expenses of the President.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation, or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Secretary shall advise the Executive Secretary in all secretarial matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and By-laws, and in the event of the death, resignation or removal of the Executive Secretary, shall assume the duties of that office until the vacancy is filled.

Section 7. The Treasurer shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or the Executive Secretary and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above-named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds.

Chapter VII. Council

Section 1. The Council shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred on the House of Delegates by the Constitution and Bylaws. The Council shall consist of the duly elected Councilors and the President, the President-elect, the three Vice-Presidents, the immediate Past-president, the Speaker of the House of Delegates, the Secretary, the Treasurer, and the Delegates to the American Medical Association. The Executive Committee of the Council shall consist of the President, the President-elect, and the Secretary of the Association, together with the Chairman of the Council, Vice-chairman of the Council, and two additional councilors to be elected annually by the Council. A majority of the full Council, including ex officio members, to wit, 14, and a majority of the full Executive Committee, including ex officio members, to-wit, 4, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Council the Executive Committee shall exercise all of the powers belonging to the Council except those powers specifically reserved by the Council to itself.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary, and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. He shall likewise hold at least one councilor district meeting each year in order to afford a forum for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expenses in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Journal of the Kentucky State Medical Association shall be the official organ of the Association and shall be published under the supervision of the Council. The Editor of the Journal shall be elected by the Council. All money received by the Journal or any member of its staff shall be paid to the Treasurer of the Association on the first of each month. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Journal of the Kentucky State Medical Association for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Section 9. In the event the office of one of the District Councilors is vacated between the meetings of the House of Delegates, the President of the Association may call a meeting of the delegates of record in the Headquarters Office from the counties of that district for the purpose of submitting one or more nominees as candidates to fill the office until the next meeting of the House of Delegates. The name or names of the nominee or nominees shall be submitted to the Council, which may elect a Councilor from them to serve until the next meeting of the House of Delegates.

Section 10. A Medico-Legal Administrator shall be appointed by the Council of the Association to serve for a term of three years. The Executive Committee of the Council shall act in an advisory capacity to the Administrator. The Association, through the Administrator shall, upon the request of any member in good standing who is a defendant in a professional liability suit, provide such member with the consultative service of competent legal counsel selected by the Administrator acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Council outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Council to defend such suit through one court.

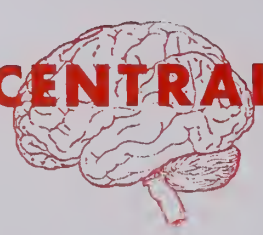
Section 11. The Council shall employ an Executive Secretary whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Council. His compensation shall be fixed by the Council. The Executive Secretary shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, Councilors, committees, boards, and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

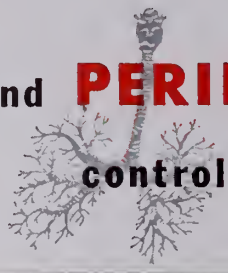
He shall attend the annual sessions, the meetings of the House of Delegates, the meetings of the Council, as many of the committee meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers and committees of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Council.

He shall be the custodian of the general papers and records of the Association (including those of

(Continued on Page 1617)

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SYNEPHRICOL® cough syrup

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Combines:

Central Antitussive Effect — mild, dependable
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Vitamin A	5,000 U.S.P. Units
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Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate	1/15 U.S.P. Oral Unit
Thiamine Mononitrate (B_1)	5 mg.
Riboflavin (B_2)	5 mg.
Niacinamide	15 mg.
Folic Acid	1 mg.
Pyridoxine HCl (B_6)	0.5 mg.
Ca Pantothenate	5 mg.
Choline Bitartrate	50 mg.
Inositol	50 mg.
Ascorbic Acid (C)	50 mg.
Vitamin E (as tocopheryl acetates)	10 I.U.
l-Lysine Monohydrochloride	25 mg.
Rutin	25 mg.
Ferrous Fumarate	30 mg.
Iron (as Fumarate)	10 mg.
Iodine (as KI)	0.1 mg.
Calcium (as $CaHPO_4$)	157 mg.
Phosphorus (as $CaHPO_4$)	122 mg.
Boron (as $Na_2B_4O_7.10H_2O$)	0.1 mg.
Copper (as CuO)	1 mg.
Fluorine (as CaF_2)	0.1 mg.
Manganese (as MnO_2)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K_2SO_4)	5 mg.
Zinc (as ZnO)	0.5 mg.

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POTASSIUM PENICILLIN-152







ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSE

REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

MANY STAPH STRAINS MORE SENSITIVE TO SYNCILLIN

BRISTOL

ORIGIN OF A NEW SYNTHETIC PENICILLIN

In March, 1957, Dr. John C. Sheehan of the Massachusetts Institute of Technology announced the total synthesis of penicillin from common raw materials, thus solving a problem which had baffled research workers for more than 15 years. Although total synthesis was not commercially practicable, this work, sponsored by Bristol Laboratories, made possible the subsequent synthesis of new penicillins not occurring in nature. Later scientists at Beecham Laboratories in England discovered that a key intermediate (6-aminopenicillanic acid) could be produced by a fermentation process. With these achievements, large scale production of synthetic penicillins became feasible.

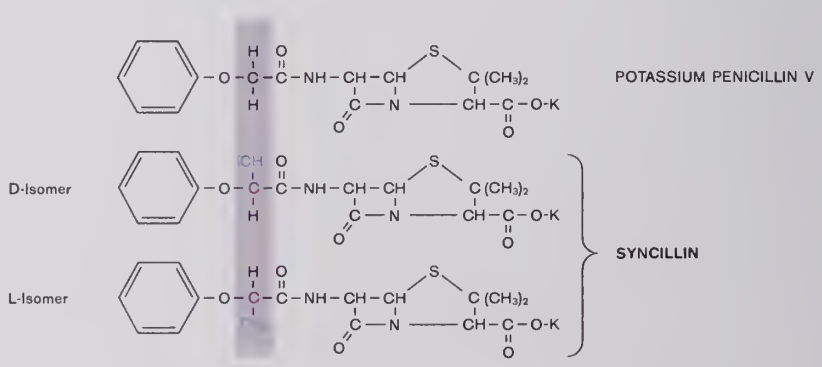
Organic chemists at Bristol then embarked upon an intensive program to develop better penicillins. Over five hundred were synthesized and underwent preliminary screening. Forty-six showed sufficient promise to warrant further investigation. Extensive microbiological, pharmacological, and clinical screening indicated that one compound, SYNCILLIN, had advantages of major importance over other penicillins.

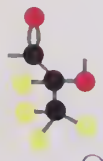
SYNCILLIN is the N-acylation product of 6-aminopenicillanic acid and α-phenoxypropionic acid (the phenylether of lactic acid). It is freely soluble in water and remarkably resistant to decomposition by acid. The acid stability of SYNCILLIN is equivalent to that of penicillin V at pH 2 and pH 3 at 37° C.[1]

SIGNIFICANCE OF MOLECULAR ASYMMETRY AND ISOMERIC COMPLEMENTARITY

SYNCILLIN has a molecular configuration similar to penicillin V, but contains an additional CH_3 group so positioned as to render the adjacent carbon atom asymmetric. (In the formulae below, the added CH_3 group is shown in blue and the asymmetric carbon atom in red.) As a result, SYNCILLIN occurs as a mixture of two isomers.

Each isomer has been synthesized in essentially pure form and found to possess distinctive chemical and biological properties. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. As produced, SYNCILLIN is a mixture of the L-isomer and the D-isomer. As will be shown later, the antibiotic effect of the clinically available mixture, SYNCILLIN, is greater than either isomer alone against many organisms. This phenomenon is referred to here as *isomeric complementarity*.





ISOMERIC COMPLEMENTARITY DEMONSTRATED IN VITRO

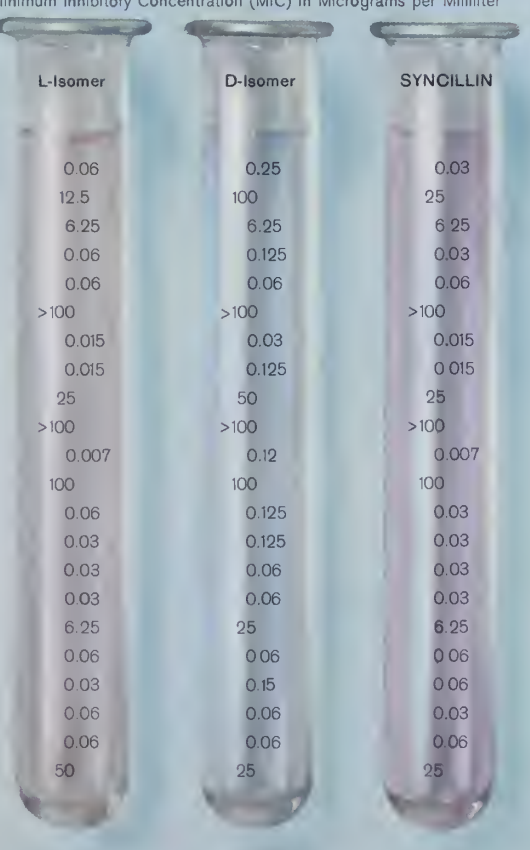
The *in vitro* minimum inhibitory concentration (MIC) of SYNCILLIN and of each of its two component isomers was determined for a variety of common pathogens and laboratory test organisms. As may be seen from Table 1, all three are highly effective against penicillin-susceptible staphylococci and against pneumococci, streptococci, gonococci, and corynebacteria; all are ineffective against Salmonella, *E. coli,* and other gram-negative coliform bacilli.

SYNCILLIN was more active against many of the test strains including some streptococci and staphylococci than either of its components. This demonstrates *in vitro* the phenomenon of isomeric complementarity.

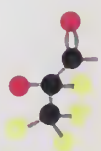
TABLE I

Minimum Concentrations of SYNCILLIN and Components Required to Inhibit a Wide Range of Bacteria

	Minimum Inhibitory Concentration (MIC) in Micrograms per Milliliter		
	L-Isomer	D-Isomer	SYNCILLIN
Bacillus anthracis	0.06	0.25	0.03
Bacillus cereus	12.5	100	25
Bacillus circulans ATCC 9961	6.25	6.25	6.25
Corynebacterium xerosis	0.06	0.125	0.03
*Diplococcus pneumoniae	0.06	0.06	0.06
Escherichia coli ATCC 8739	>100	>100	>100
Gaffkya tetragena	0.015	0.03	0.015
Micrococcus flavus	0.015	0.125	0.015
Salmonella paratyphi A	25	50	25
Salmonella typhosa	>100	>100	>100
Sarcina lutea ATCC 10054	0.007	0.12	0.007
Shigella sonnei	100	100	100
Staphylococcus aureus 209P	0.06	0.125	0.03
Staphylococcus aureus var. Smith	0.03	0.125	0.03
Streptococcus agalactiae ATCC 1077	0.03	0.06	0.03
Streptococcus dysgalactiae ATCC 9926	0.03	0.06	0.03
Streptococcus faecalis PCI 1305	6.25	25	6.25
*Streptococcus pyogenes 203	0.06	0.06	0.06
*Streptococcus pyogenes Digonnet	0.03	0.15	0.06
Streptococcus pyogenes 2320	0.06	0.06	0.03
Streptococcus pyogenes 23586	0.06	0.06	0.06
Vibrio comma	50	25	25



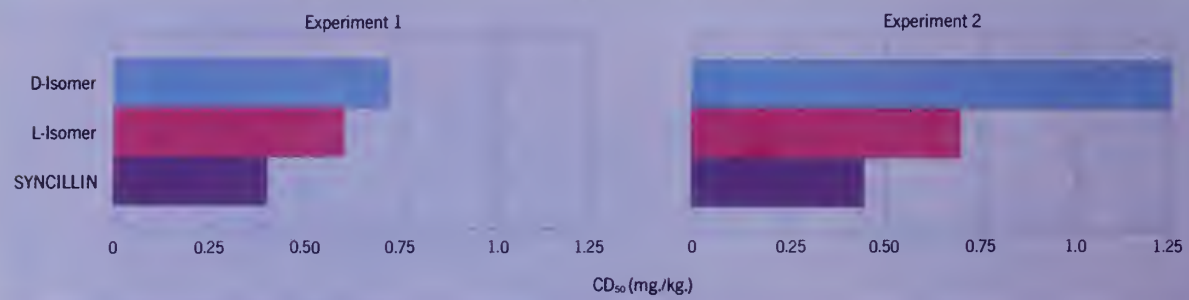
Serial dilution technique in heart infusion broth *10% serum added



ISOMERIC COMPLEMENTARITY CONFIRMED IN VIVO

To determine the median curative dose (CD_{50}) mice were infected with 100 times the lethal dose of *Staphylococcus aureus*. Each penicillin being tested was administered intramuscularly at the same time, and the dose required to cure half the animals determined. The greater effect of the mixture of the two isomers (SYNCILLIN) is shown in two independent experiments. (See Figure 1.) Note that isomeric complementarity is thus confirmed *in vivo*.

FIGURE 1 — Median Curative Dose (CD_{50}) for *Staphylococcus aureus* (var. Smith) Infections

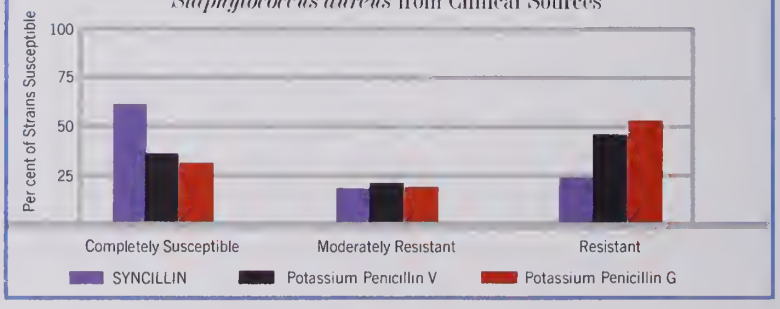


MANY STRAINS OF STAPHYLOCOCCI MORE SENSITIVE TO SYNCILLIN

SYNCILLIN has been tested against a large number of strains of *Staphylococcus aureus* isolated from clinical sources. Many organisms resistant to potassium penicillin G and potassium penicillin V proved sensitive to SYNCILLIN.

Wright[2] performed sensitivity studies on 54 strains, the majority of which were resistant or moderately resistant to penicillin V and penicillin G. Thirty-two (60%) of the strains were sensitive to SYNCILLIN, approximately twice as many as with the other penicillins. (See Figure 2.) In two-thirds of the isolates, SYNCILLIN produced inhibition at concentrations lower than those required for either of the other antibiotics. One strain was more sensitive to penicillin G.

FIGURE 2 — *In Vitro* Sensitivity of 54 Strains of Coagulase-Positive *Staphylococcus aureus* from Clinical Sources



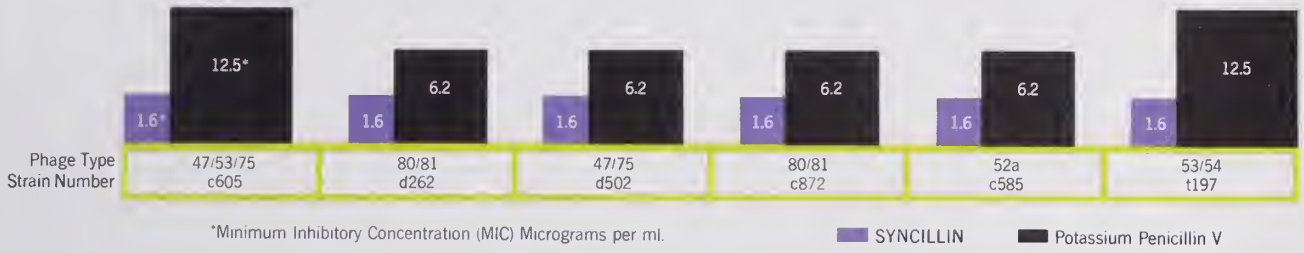
Adapted from Wright[2]



Of equal interest are the findings of White.[3] Six penicillin-resistant strains of staphylococci were isolated from hospital infections. None was sensitive to potassium penicillin V. All were sensitive to SYNCILLIN. (See Figure 3.)

FIGURE 3

Minimum Concentrations of SYNCILLIN Required to Inhibit Hospital Strains of *Staphylococcus aureus* Resistant to Potassium Penicillin V

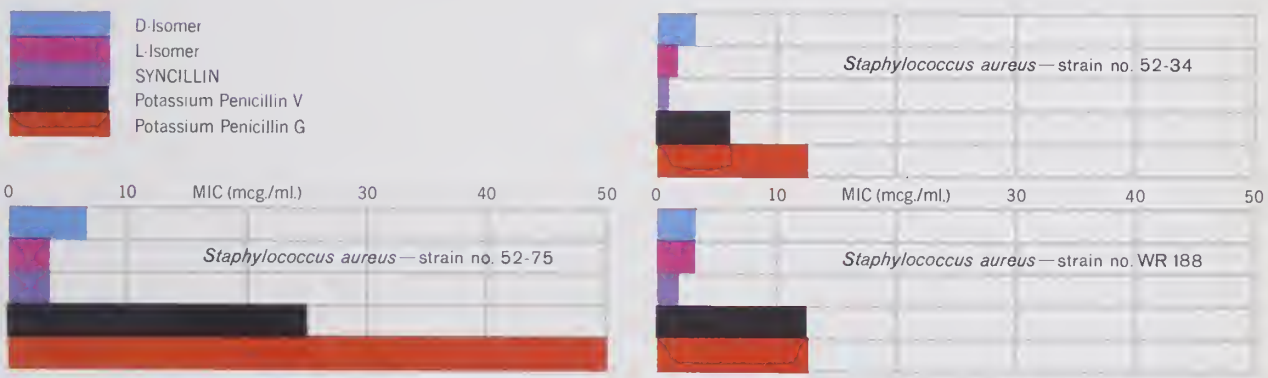


The efficacy of SYNCILLIN against the type 80/81 Staphylococcus (dangerous and widespread in hospitals) is worthy of special attention.

The complementary action of the component isomers is also seen with strains of staphylococci resistant to penicillins. Note that SYNCILLIN is more effective than either isomer against strains 52-34 and WR 188. (See Figure 4.) Against all three strains, SYNCILLIN is effective at concentrations below serum levels, while penicillins V and G are ineffective.

FIGURE 4

Minimum Inhibitory Concentrations (MIC) for Coagulase-Positive Penicillin-Resistant Strains of *Staphylococcus aureus*



Isomeric complementarity has thus been demonstrated for:

—— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

—— *penicillin-susceptible staphylococci* in vivo *(Figure 1)*

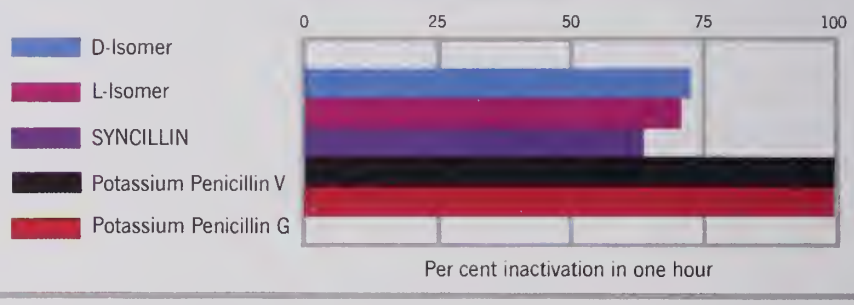
—— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

ISOMERIC COMPLEMENTARITY SHOWN BY REDUCED RATE OF INACTIVATION BY PENICILLINASE

Bacterial resistance to penicillin has been attributed to the action of penicillin-inactivating enzymes produced by the invading organisms.[4] As shown in Figure 5, SYNCILLIN is less affected by staphylococcal penicillinase than either of its component isomers – a further demonstration of isomeric complementarity. Further, SYNCILLIN is shown to be less inactivated by this enzyme than penicillin V and penicillin G.

Resistance to SYNCILLIN develops in a slow, step-wise manner characteristic of other penicillins, in contrast to the usually rapid development of resistance to streptomycin.

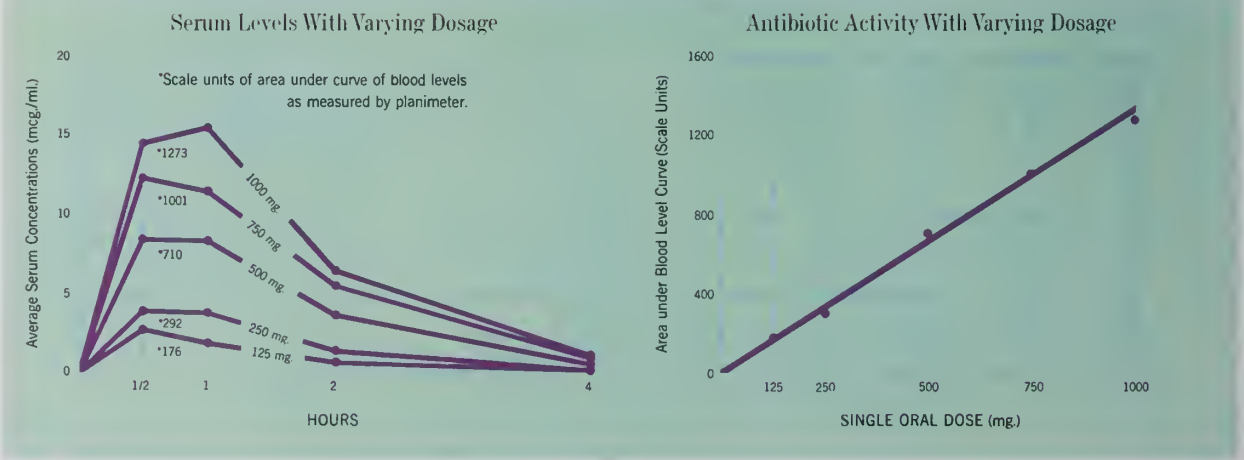
FIGURE 5—Effect of Staphylococcal Penicillinase on Different Penicillins



ANTIBIOTIC ACTIVITY DIRECTLY PROPORTIONAL TO ORAL DOSAGE

Cronk[5] studied blood levels after administering varying amounts of SYNCILLIN. (Figure 6.) Total antibiotic activity (obtained by measuring areas under curves with a planimeter) increases rapidly as the dose is doubled. These data show that increased dosage markedly increases serum concentration and thus may enhance the drug's effectiveness.

FIGURE 6



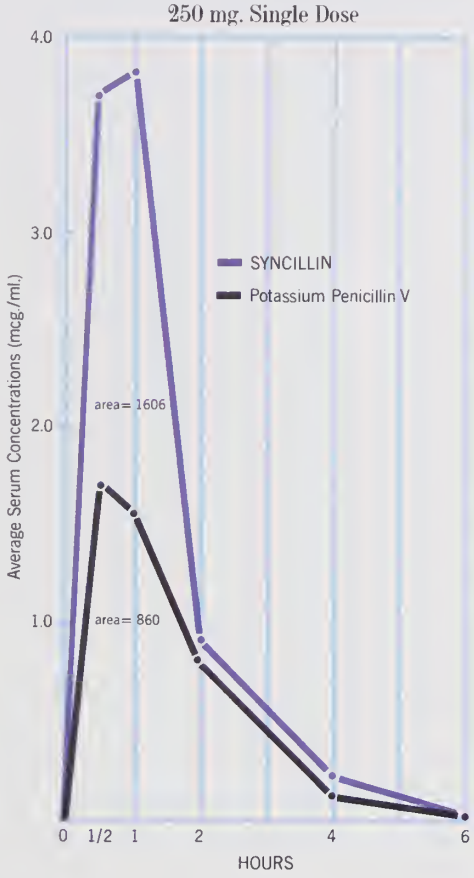
BLOOD LEVELS TWICE AS HIGH AS WITH POTASSIUM PENICILLIN V AFTER ORAL ADMINISTRATION

Wright[6] performed comparative crossover blood level studies on volunteer subjects receiving equivalent amounts of potassium penicillin V and SYNCILLIN. The peak concentrations attained during the first hour after administration were twice as high with SYNCILLIN.

The total antibiotic activity as measured by the area under the curves (see Figure 7) indicates an almost 2 to 1 superiority of SYNCILLIN (1606) over potassium penicillin V (860).

The higher blood levels may be of value with organisms of only moderate penicillin-sensitivity where doubling the blood concentration may be essential for effective bactericidal action. In addition these higher levels may be necessary where there is infection in areas with a poor blood supply.[7] Under these circumstances a higher blood concentration may provide the increased diffusion pressure required to deliver adequate amounts to the tissue.

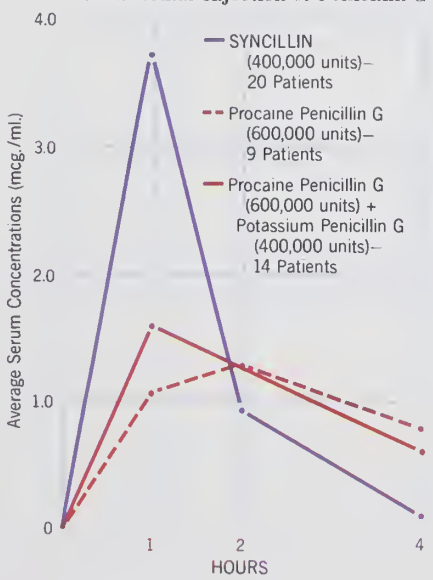
FIGURE 7
20 Subject Crossover
250 mg. Single Dose



BLOOD LEVELS MUCH HIGHER THAN WITH INTRAMUSCULAR PENICILLIN G

In addition, blood levels attained with oral SYNCILLIN[6] are much higher than those with intramuscular penicillin G.[8a, b] (See Figure 8.) Note that the level at one hour for SYNCILLIN (3.8 mcg./ml.) is more than twice as high as with procaine penicillin G, even when reinforced with potassium penicillin G (1.6 mcg./ml.). Since penicillins are *bactericidal,* these intermittent high serum levels can be clinically significant. Thus, SYNCILLIN offers the promise of superior efficacy via the safer oral route.

FIGURE 8—Serum Levels after Oral Administration of SYNCILLIN (250 mg.) and after Intramuscular Injection of Penicillin G



REDUCED HAZARD OF SERIOUS ALLERGENICITY BY SAFER ORAL ROUTE

SYNCILLIN has been administered in multiple doses to 437 patients and volunteers. One patient developed itching during therapy, possibly an allergic side effect. Another had a purpuric rash, but no relationship to SYNCILLIN was established. No reactions were observed in 9 patients with a known history of sensitivity to penicillin.

While the above data suggests the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *The usual precautions for oral penicillin therapy should be observed.* Patients with histories of asthma, hay fever, urticaria, or previous penicillin-sensitivity should especially be watched carefully. Since SYNCILLIN is administered orally, it may be expected to be safer than parenteral penicillin.

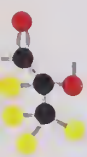
As Flippin[9] recently stated, "... it is well established that serious allergy to the drug [penicillin] is most likely to occur following parenteral administration, especially after repeated intramuscular injections; the oral route is least likely to initiate severe hypersensitivity reactions. This can be explained partly by the fact that when reactions develop following oral medication, they are usually slow enough to treat symptomatically; thus the progression of the reaction can usually be interrupted.... In view of the relatively high incidence of severe allergy to injectable penicillin, it would seem advisable to employ oral penicillin routinely, except in the control of infections involving the blood stream, endocardium, meninges, etc., in which cases the parenteral route remains the preferred treatment."

SYNCILLIN, like other penicillins, is essentially free of other toxicity. No hematopoietic, hepatic, or renal toxicity was observed in 210 volunteers receiving 1 gm. daily for 2 to 3 weeks.[10]

CLINICAL EFFICACY DEMONSTRATED IN PENICILLIN-SENSITIVE INFECTIONS

Clinical trials conducted by Blau and Kanof,[11] White,[12] Prigot,[13] Robinson,[14] Dube,[15] Ferguson,[16] Rutenburg,[17] Richardson,[18] Bunn,[19] Cronk,[5] Kligman,[10] and Yow [20] demonstrated the efficacy of SYNCILLIN in a variety of streptococcal, staphylococcal, pneumococcal, and gonococcal infections. Conditions treated included respiratory, skin, soft tissue, wound, and chronic urinary tract infections; acute gonorrhea; cellulitis; septicemia; otitis media; gingivitis; and Vincent's angina. In a few patients SYNCILLIN was used for rheumatic fever or gonorrheal prophylaxis.

One hundred seventy-two of one hundred ninety-six patients responded favorably to SYNCILLIN. The failures included 1 patient with pustular dermatoses, 10 elderly patients with chronic urinary tract infections, 1 patient with gonorrhea, 1 patient with a gram-negative infection, and 10 patients with staphylococcal infections. Lack of response of staphylococcal infections was attributed to the presence of resistant organisms or local suppurative foci requiring drainage.



Relatively few side effects were encountered. One patient experienced moderate itching of the skin which was controlled by an antihistamine. Another reported pruritus ani which did not interfere with therapy. Diarrhea occurred in 4 instances. There was one purpuric rash, but no relationship to SYNCILLIN could be established.

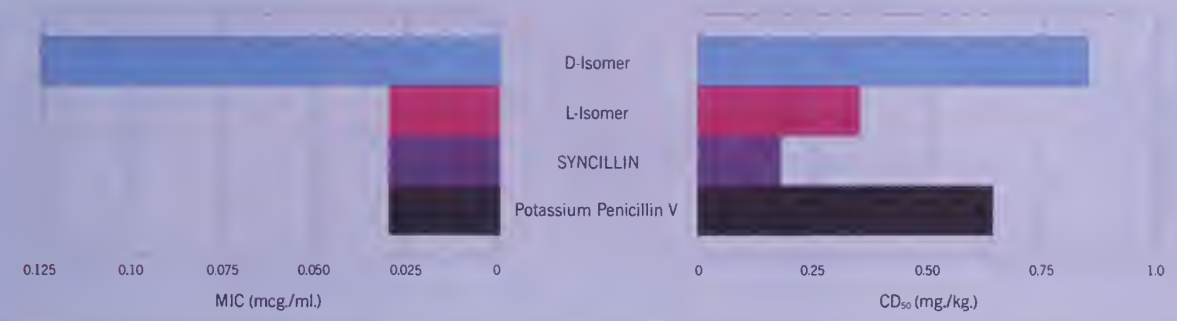
Clinical response usually begins within 24 hours in infections susceptible to SYNCILLIN. Recovery occurs in 4 to 7 days depending upon the severity of the infection. Gonorrheal infections respond very promptly to SYNCILLIN; 500 mg. b.i.d. for two days usually produce bacteriologic cures.

IMPROVED ANTIBIOTIC EFFECT FROM COMPLEMENTARY ACTION OF ISOMERS

SYNCILLIN is a mixture of isomers. The L-isomer is 2 to 17 times more active than the D-isomer against many of the organisms tested. Furthermore, the D- and L-isomers have other distinguishing chemical, pharmacological, and microbiological properties. Their *in vivo* and *in vitro* activities differ for many important pathogens. *Against many of the organisms tested, the combination of isomers* (SYNCILLIN) *is much more active than the stronger isomer alone.* This phenomenon of isomeric complementarity is not always demonstrable, for in a few instances SYNCILLIN is slightly less active.

Isomeric complementarity has previously been demonstrated *in vitro* (Figure 4) and *in vivo* (Figure 1). Figure 9 reveals a third form of superiority related to isomeric complementarity. Equal concentrations of SYNCILLIN and penicillin V were required to inhibit this growth of staphylococci *in vitro*. But, *in vivo*, a much smaller amount of SYNCILLIN *(one-third that of penicillin V)* was effective in an experimental infection with the same strain. These observations on complementary action indicated the advantage of producing the mixture of isomers as the medication to be made available for clinical therapy.

FIGURE 9 — Comparison of CD_{50} and MIC Values Against *Staphylococcus aureus* (var. Smith)



Isomeric complementarity has thus been demonstrated for:

— *certain penicillin-susceptible streptococci, staphylococci and corynebacteria* in vitro *(Table 1)*

— *penicillin-susceptible staphylococci* in vivo *(Figures 1 and 9)*

— *penicillin-resistant staphylococci* in vitro *(Figure 4)*

— *staphylococcal penicillinase antibiotic inactivation (Figure 5)*

Indications:

SYNCILLIN is recommended in the treatment of infections caused by pneumococci, streptococci, gonococci, corynebacteria, and penicillin-sensitive staphylococci. In addition, SYNCILLIN is effective against certain strains of staphylococci resistant to other penicillins.

SYNCILLIN, like other oral penicillins, is not recommended at the present time in deep-seated or chronic infections, subacute bacterial endocarditis, meningitis, or syphilis.

Dosage:

125 mg. or 250 mg. three times daily, depending on the severity of infection. Larger doses (e.g., 500 mg. t.i.d.) may be used for more severe infections. SYNCILLIN may be administered without regard to meals.

Beta hemolytic streptococcal infections should be treated with SYNCILLIN for at least ten days.

Precautions:

While present data suggest the possibility of reduced allergenic hazard, no definite conclusions may be drawn at this time. *Therefore the usual precautions with oral penicillin therapy must be observed.* Patients with histories of asthma, hay fever, urticaria, or previous reactions to penicillin should be watched with special care.

Diarrhea has been reported occasionally following heavy dosage. If this occurs, the interval between dosages should be lengthened.

If superinfection occurs during therapy, appropriate measures should be taken.

Since some strains of staphylococci are resistant to SYNCILLIN as well as to other penicillins, cultures and sensitivity tests should be performed where indicated by clinical judgment. As is true with all antibiotics, clinical response does not always correlate with laboratory bacterial sensitivity reports.

Supply:

125 and 250 mg. tablets, bottles of 25 and 100. 125 mg. powder for oral solution, 60 ml. vials.

References: I. Lein, J.: Microbiology report to Bristol Laboratories Inc. 2. Wright, W. W.: Microbiology report to Bristol Laboratories Inc. 3. White, A. C.: Microbiology report to Bristol Laboratories Inc. 4. Dubos, R. J.: Bacterial and Mycotic Infections of Man, 3rd edition, Philadelphia, J. B. Lippincott Co., p. 690. 5. Cronk, G. A.: Clinical report to Bristol Laboratories Inc. 6. Wright, W. W.: Clinical report to Bristol Laboratories Inc. 7. Kass, E. H.: Am. J. Med. *18*:764 (May) 1955. 8a. White, A. C.; Couch, R. A.; Foster, F.; Calloway, J.; Hunter, W., and Knight, V.: in Welch, H. and Marti-Ibañez, F.: Antibiotics Annual — 1955-1956, Medical Encyclopedia, Inc., New York, 1956, p. 490. b. Data on file — at Bristol Laboratories. 9. Flippin, H. F.: Pennsylvania M. J. *62*:864 (June) 1959. 10. Kligman, A.: Clinical report to Bristol Laboratories Inc. 11. Blau, S., and Kanof, N.: Clinical report to Bristol Laboratories Inc. 12. White, A. C.: Clinical report to Bristol Laboratories Inc. 13. Prigot, A.: Clinical report to Bristol Laboratories Inc. 14. Robinson, C.: Clinical report to Bristol Laboratories Inc. 15. Dube, A. H.: Clinical report to Bristol Laboratories Inc. 16. Ferguson, B.: Clinical report to Bristol Laboratories Inc. 17. Rutenburg, A. M.: Clinical report to Bristol Laboratories Inc. 18. Richardson, J. H.: Clinical report to Bristol Laboratories Inc. 19. Bunn, P. A.: Clinical report to Bristol Laboratories Inc. 20. Yow, E. M.: Clinical report to Bristol Laboratories Inc.

BRISTOL

major therapeutic advantages accompany molecular asymmetry

SYNCILLIN



(Continued from Page 1603)

the Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees of their appointments and duties.

He shall account for and promptly turn over to the Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Treasurer. He shall, within thirty days preceding each annual session, submit his financial books and records to a certified public accountant, approved by the Council, whose report shall be submitted to the House of Delegates.

He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor of the Journal of the Kentucky State Medical Association under supervision of the Council and in a similar capacity to the extent that other publications are authorized by the House of Delegates.

He shall perform such additional duties as may be required by the House of Delegates, the Council, or the President, and shall employ such assistants as the Council may direct. He shall serve at the pleasure of the Council, and in the event of his death, resignation, or removal, the Council shall have the power to fill the vacancy. From time to time, or as directed by the Council, he shall make written reports to the Council and House of Delegates concerning his activities and those of the Headquarters Office.

Chapter VIII. Committees

Section 1. The Standing Committees shall be as follows:

A Committee on Scientific Assembly and Arrangements
A Committee on Public Information and Service
A Committee on Medical Education and Economics
A Committee to Study Constitution and By-Laws
A Legislative Committee

and such other committees as may be necessary. The Headquarters Office at 1169 Eastern Parkway, Louisville 17, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President, Secretary and Executive Secretary shall be ex officio members of all committees serving without power to vote except as otherwise specified.

Section 2. The Committee on Scientific Assembly and Arrangements shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee and Vice Chairman thereof. The remaining three members shall serve for terms of three years each, with the term of one member expiring each year and the vacancy filled by appointment of the President. The Chairman of the Committee on Scientific Exhibits and the Chairman of the Committee on Technical Exhibits shall be ex-officio members of the Committee. The Committee shall determine the character and scope of the scientific proceedings of the Association subject to the Constitution and Bylaws and the instructions of the House of Delegates or of the Council, and to that end may invite the Chairman of its subcommittee to meet and consult with it. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions, and other business shall be presented, which program shall be adhered to by the Association as nearly as practicable. No county society as such shall serve as host society to the annual meeting.

Section 3. A Committee on Public Information and Service shall be appointed by the Council of the Association whose members shall serve at the discretion of the Council. The Council will annually designate its chairman. It shall be the duty of this committee to keep in active touch with public opinion. It shall keep the public informed of such developments that will constitute a service to the public. It shall promote such immediate and long-range educational programs, both to the public and within the profession, as are deemed in the best interest of both. Its work shall be done with dignity becoming a great profession and that wisdom which makes effective its work and influence.

Section 4. The Committee on Medical Education and Economics shall be appointed by the Council whose members shall serve at the pleasure of the Council. The Council shall annually designate the chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall continually strive to serve as a liaison between the public and the Medical Association in those matters.

Section 5. The Committee to Study the Constitution and Bylaws shall be appointed by the Speaker of the House of Delegates acting in conjunction with the Vice Speaker and the Nominating Committee and shall make a continuing study of the Constitution and By-Laws. The Committee shall annually recommend to the House of Delegates such revisions as changing times and conditions dictate.

Section 6. The Legislative Committee shall be appointed annually by the Council of the Association whose members shall serve at the pleasure of the Council. The Council shall each year designate the chairman of the committee. Under the direction of the Council, it shall represent the Association in securing and enforcing legislation in the interest of public health and the science of medicine.

Chapter IX. Assessments and Expenditures

Section 1. The annual dues for membership in this Association shall be as follows: (1) **Active Members, $50.00,** *except Active Members who devote all of their time to teaching or research and have no private practice, $25.00;* (2) Associate Members, $8.00; (3) Inactive Members, $8.00; (4) Emeritus Members, no dues; (5) Student Members, $1.00; (6) Honorary Members, no dues. Dues fixed by these Bylaws shall constitute assessments against the component societies. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association, together with

(Continued on Page 1619)

whenever there is inflammation, swelling, pain

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VARIDASE is not an anti-infective, but by increasing the permeability of the fibrin wall, it eases penetration of natural regenerative factors and fosters healthy tissue growth, making infection less likely.

VARIDASE Buccal Tablets contain: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

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(Continued from Page 1617)

the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendlv overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. In sparsely settled sections two or more county societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The county society thus combined shall not lose any of its privileges and representation. The active members of each county society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 6. Each county society shall be the sole judge of the qualifications of its own members. All members of the component county societies shall be members of the Kentucky State Medical Association, and shall be classified in accordance with Chapter I, Section 2, of these Bylaws. Any physician who desires to become a member of the Kentucky State Medical Association shall first apply to the county society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 7 and/or 10 of this chapter, no physician shall be an active member of a county society in any county other than the county in which he resides.

Section 7. Any physician who may feel aggrieved by the action of the component county society of the county in which he resides, in refusing him membership or in suspending or expelling him, shall have the right to appeal to the Council, which, upon a majority vote, may permit him to become a member of a component county society in a county which is adjacent to the county in which he resides.

Section 8. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 9. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 10. A physician whose residence is closer to the headquarters of an adjacent county society than it is to the headquarters of the county society of the county in which he resides, may, with the consent of the county society within whose jurisdiction he resides, hold membership in said adjacent county society.

Section 11. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 12. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 13. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association. The term of a delegate is from the beginning of the annual meeting of the House to which he was elected to serve to the beginning of the next annual meeting, but it may be for one or more years at the discretion of the county society. Each component society may be represented by one delegate for each 25 members in good standing plus one delegate for one or more members in excess of multiples of 25. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association not later than 45 days before the next annual session. It shall be the obligation of the county medical society which elects delegates to serve more than one year to provide the KSMA Headquarters Office with a completed certified list of delegates to represent that county for that particular year.

Section 14. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 15. The secretary of each county society shall report to the Journal of the Kentucky State Medical Association full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Chapter XIII. Amendments

These Bylaws may be amended by any annual session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.



From the files of the
COMMITTEE FOR THE
STUDY OF MATERNAL MORTALITY



Report of Maternal Mortality Committee of KSMA

The Kentucky Maternal Mortality Committee has now completed the second year of its study of reported maternal deaths. This is a combined report for the years 1957 and 1958.

The national statistics reveal a continued decline in the maternal death rate. As recently as 1915 the national figure was 61 deaths per 10,000 live births. For the year 1957 this had been reduced to 4.3 deaths per 10,000 live births. An analysis of the Kentucky figures is presented in Table I.

TABLE I
Kentucky Maternal Mortality Rates, 1957-58 by Race

	Kentucky Deliveries	1957 Deaths	Rate/ 10,000 Live Births	1958 Deliveries	1958 Deaths	Rate/ 10,000 Live Births
White	68,289	22	3.22	67,626	21	3.11
Non-white	6,309	9	14.25+	6,430	4	6.22
Total	74,598	31	4.15+	74,056	25	3.38

TABLE II
Maternal Deaths by Place of Delivery

Place Delivered	1957 No. Deliveries	1957 Deaths	Rate/ 10,000 Live Births	1958 No. Deliveries	1958 Deaths	Rate/ 10,000 Live Births
Hospital	68,199	26	3.81	68,199	23	3.37
Other	6,399	5	7.81	5,857	2	3.41

It should be pointed out that a fairly large number of deliveries that occur in the physician's office are included in the above "hospital group." While this is far from ideal it is better than a home delivery where complications are more difficult to manage.

TABLE III
Maternal Deaths by Attendant

Attendant	1957 No. Deliveries	1957 Deaths	Rate/ 10,000 Live Births	1958 No. Deliveries	1958 Deaths	Rate/ 10,000 Live Births
Physician	71,799	27	3.76	71,311	24	3.37
Midwife-includes FNS*	2,641	1	3.79	2,567	0	0
Other	158	3	189.87	178	1	56.18

Over 25 per cent of the deaths for both years occurred among women having no prenatal care. It is apparent that more public understanding is necessary as to the importance of this means of averting complications, especially for toxemia and early treatment for hemorrhage.

Of the eight deaths who had no prenatal care for 1958 two were the result of toxemia. One was an undetected, unsuspected sixteen-year-old diabetic. Both of the toxemias were in the fifteen- to twenty-year bracket. A further breakdown is listed in the following table:

TABLE IV
Maternal Deaths by Age and Diagnosis
(Patients Having No Prenatal Care)

No.	Age	Diagnosis
1	16	Diabetes
2	16, 19	Toxemia
1	21	Ectopic Pregnancy
1	29	Criminal Abortion
1	33	Hemorrhage and Air Embolism
1	19	Hemorrhage with Malignant Hydatid Mole
1	38	Hemorrhage from Ruptured Cornual Pregnancy

TABLE V
Maternal Deaths by Prenatal Care Received

No. Visits	1957	% of Total	1958	% of Total
0	8	25.8	8	32.0
1-5	8	25.8	7	28.0
6-10	6	19.3	6	24.0
11+	2	6.5	0	
Not stated	7	22.6	4	16.0
Total	31	100	25	100

* Frontier Nursing Service

It is difficult to say arbitrarily how many visits constitute adequate prenatal care, but at least six have been set as a basic minimum for complete care. It is apparent for both years under study that there were less than 25 per cent who had recorded visits from 6 to 10 in number. Only four of the mothers who died in 1958 were seen in the first trimester; nine made their initial visit in the second trimester; two were in their third trimester.

TABLE VI
Maternal Deaths by Method of Delivery

	1957	% of Total	1958	% of Total
Spontaneous	10	32.2	6	24.0
Operative	11	35.5	11	44.0
Not delivered including postmortem deliveries	7	22.6	6	24.0
Not answered	3	9.7	2	8.0
Total	31	100	25	100

TABLE VII
Maternal Deaths by Route of Delivery

	1957	% of Total		1958	% of Total
Vaginal	14	45.1		11	44.0
			low cervical	(2)	8.0
Caesarean ante mortem	4	12.9	sectional classical	(4)	16.0
postmortem	3	9.7		0	0.0
Abortion	3	9.7		2	8.0
Not delivered	3	9.7		2	8.0
Ectopic	1	3.2		2	8.0
Not answered	3	9.7		2	8.0
Total	31	100		25	100

TABLE VIII
Maternal Deaths by Autopsies Obtained

	1957	Per cent	1958	Per cent
Obtained	9	29.0	8	32.0
Not obtained	20	64.5	15	60.0
Not known	2	6.5	2	8.0
Total	31	100	25	100

The number of deaths compared with the parity of the mother isn't too meaningful without information on the number of mothers delivered in each group to calculate the rate. This will be available for this year, 1959. The committee was glad to note the reduced number of "not knowns" for the current year indicating greater physician cooperation in supplying information for the study.

TABLE IX
Maternal Deaths by Parity

	1957	1958
0	3	11
1-3	13	7
4-6	5	4
7+	4	3
Not answered	6	0
Total	31	25

There was an increase in the number of primagravida deaths for the year 1958. Seven of those occurred in the 15-20-year-old group.

TABLE X
Maternal Deaths by Age Group

Age	1957	1958
15-20	7	7
21-25	3	4
26-30	8	2
31-35	6	4
36 and over	7	7
Not answered	0	0
Total	31	25

Beginning with the year 1959 the age of all patients delivered has been tabulated, so in the future rates on the above data can be computed.

It should be noted there was a significant drop in the deaths for the year 1958 in the 26-30 age group where we would expect to have a large number of deliveries. However, the number of deaths remained rather high for both the very young and older groups for both years.

TABLE XI
Classification of Maternal Deaths by Cause

	1957	% of Total		1958	% of Total	
Hemorrhage		13	41.9		10	40.0
Abruptio	2			2		
Placenta previa	2			1		
Abortion	0			0		
Afibrinogenemia	.0			1		
Ectopic pregnancy	3			1		
Postpartum atony	2			1		
Ruptured uterus	4			1		
Toxemia		7	22.6		7	28.0
Infection		3	9.7		4	16.0
Abortion, septic including alleged criminal	2			1		
Peritonitis				2		
Broncho-pneumonia	1			1		
Other		9*	29.0		5*	20.0
Amniotic fluid embolus				1		
Blood dyscrasia	1* counted also with hemorrhage					
Cerebrovascular accident	1					
Diabetes				2		
Pulmonary embolus	3			1		
Cardiac arrest	1					
Hydatidiform mole				1* counted also with hemorrhage		
Transfusion reaction	3					
Total	31		103.2	25		104

* Percentages total more than 100% because of double classification.

The Future

Beginning with this year we will be able to obtain more significant statistics due to more complete tabulating of information from birth certificates. We must remember the records are only as complete as we make them by supplying the information called for on the birth and death certificates. Equally important is the continued improvement in the hospital and office case records written by the person who attends the patient.

It is hoped that a higher autopsy rate might be obtained especially for those deaths occurring in hospitals having pathologists. It is only by utilizing every service available that more correct information can be obtained and the maternal death rate further reduced.

Norton Seminar Set for Dec. 17

Physicians are reminded that December 17 is the date of the second Norton Memorial Infirmary Postgraduate Medical Seminar to be held in the Norton auditorium. The program is sponsored by the infirmary's board of trustees in cooperation with the Kentucky Academy of General Practice.

The complete scientific program was carried in the November issue of The Journal of KSMA.

Dr. Camp of Illinois Society Dies

Harold M. Camp, M.D., secretary-treasurer of the Illinois State Medical Society since 1924, died October 17 at the age of 74. Doctor Camp had visited the Annual Meetings of the Kentucky State Medical Association on a number of occasions. The Harold M. Camp Memorial Fund for cancer research at Northwestern University Medical School, Chicago, has been established.

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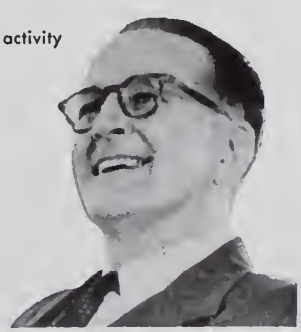
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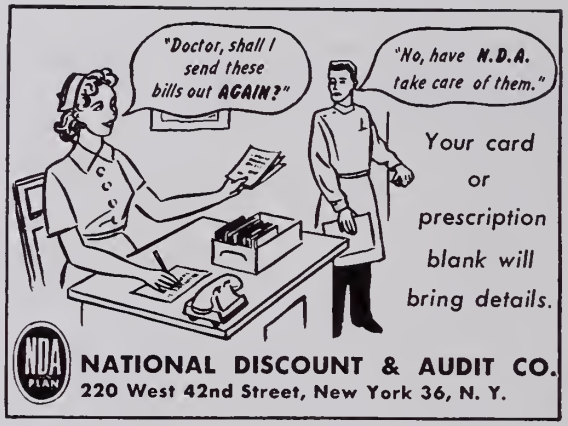


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edited by

Sam. A. Overstreet, M.D.

Under the Supervision of the Council

Volume Fifty-Seven • January through December • 1959

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